

HIPAA AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION - CASE REPORT

Instructions to ETSU Health Faculty and Staff

In general, case reports must be de-identified. This means the investigator must have no actual knowledge that the information to be presented or published could be used to identify the patient who is the subject of the information. If the case report will be deidentified, an investigator always has the option to utilize the HIPAA Authorization for Use/Disclosure of Protected Health Information - Case Report, if they so choose, but it is not required in such an instance.

If the case report includes any HIPAA identifier, or an image of the face or any part of the face, other image showing a unique identifier, or if the case is so unique that the identity of the patient would be readily known, a HIPAA Authorization for Use/Disclosure of Protected Health Information - Case Report is required by law. The form must be completed by the patient or the patient's legally authorized representative before any presentation or publication of the case. A copy of this Authorization must be uploaded to the patient's medical record.

This form must be used for case reports that involve the use/disclosure of protected health information maintained by ETSU Health. Prior to using this form, make sure you understand the content of the form and can advise the patient on which records you will need for your case report. This form must be properly completed to be valid.

Photographs:

- ✓ If clinical photographs exist that you wish to use for your case report, ensure the patient checks beside "Photographs and Imaging" on this form.
- ✓ If you plan to take case status photographs for inclusion with your case report, the patient must complete the Consent to Photography - Case Report form.

Important Note: Case reports on four (4) or more patients require IRB approval. Please see [IRB Policy 5](#) for guidance.

All fields that require attention are **highlighted**.

This form is ready for use when you have:

- ✓ Filled out all **highlighted fields**.
- ✓ Deleted this instruction page.

A copy of each completed form should be scanned into the patient's ETSU Health electronic medical record.

If at any time during this process you have questions, please do not hesitate to contact the HIPAA Compliance Office. We will be happy to assist you.

HIPAA Compliance Office

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Name of Patient/Previous Names

Date of Birth

Last 4 Digits of Social

By signing this Authorization Form, you are giving your authorization for East Tennessee State University, Medical Education Assistance Corporation, or the Northeast Tennessee Community Health Centers, Inc. (hereinafter referred to collectively as "ETSU Health") to use/disclose your health information for a case report.

Purpose: A case report is a medical or educational activity that involves the presentation and/or publication of information and analysis for the purpose of highlighting an interesting or unique clinical experience, observation, treatment, relationship, or outcome. A case report may be published in paper or electronic form for others to read. A case report may also be presented at a conference or meeting.

Protected Health Information to be disclosed:

_____ Entire Record; or _____ Treatment Dates from ____/____/____ to ____/____/____.

Check the types of records to be released if not requesting entire record:

___ Medical History, Examination, Reports ___ Surgical Reports ___ Immunizations

___ Hospital Records Including Reports ___ Treatment or Tests ___ X-ray Reports

___ Allergy Records ___ Laboratory Reports ___ Prescriptions

___ Consultations ___ Photographs and Imaging

Other (Specify): _____

Specific permission must be given to release sensitive categories of your Protected Health Information. If we are permitted to use/disclose these records please **initial** below:

_____ STDs _____ Mental/Behavioral Health _____ HIV/AIDS

Once the case report is published or presented, your health information including any photographs, images, or other recordings may no longer be protected by federal and state privacy laws. This means this information may be re-disclosed without asking your permission

Revocation: You can change your mind and cancel this authorization at any time. If you want to change your mind, you must let ETSU Health know in writing to: **Insert Appropriate Office Mailing Address**. If you change your mind, ETSU Health will not be able to take back the information that has already been used/disclosed under this authorization.

Expiration Date: This authorization will expire when the intended purpose has been fulfilled.

You do not have to sign this form. If you refuse to sign this form, your medical treatment will not be affected. By signing below, you confirm that you had an opportunity to review this form and ask questions. By signing below, you confirm that this form accurately reflects your wishes.

Signature of Patient or Legally Authorized Representative Date

If this document is signed by someone other than the Patient, such as a person holding a Durable Power of Attorney for Healthcare, the signer must state his/her relationship to the Patient, describe his/her authority to act on the Patient's behalf, and provide a copy of the Durable Power document:
