HIPAA Release Form

Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.

This case report may be performed only by using personal information relating to your health. National data protection regulations give you the right to control the use and disclosure of your medical information. Therefore, by signing this form, you specifically authorize your medical information to be used or disclosed as described below.

Section I

I, ______________________________[Study Participant Name], give my permission for ___________________________________ [Medical Provider] to share the information listed in Section II of this document with the person(s) or organization(s) I have specified in Section IV of this document.

Section II – Health Information

I would like to give the above healthcare organization permission to:

Tick as appropriate

☐ Disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions.

Or

☐ Disclose my complete health record except for the following information

- ☐ Mental health records
- ☐ Communicable diseases including, but not limited to, HIV and AIDS
- ☐ Alcohol/drug abuse treatment records
- ☐ Genetic information
- ☐ Other (Specify)

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Section III – Reason for Disclosure

The main reason for sharing this protected health information (PHI) is to be able to conduct a case study and present and/or publish the results. The results of the case study may be published in one or more publications. Although information obtained from your medical record and chart will be disclosed in the publication, we will not publish identifiers such as your name, address, telephone number or government-issued identification number. Identifiers may be used, however, for sharing information with an agency authorized to receive reports on adverse events or situations that may help prevent placing other individuals at risk.

Section IV – Who Can Receive My Health Information

I give authorization for the health information detailed in section II of this document to be shared with the following individual(s) or organization(s)

Name: ____

Organization: ____

Address: ____

PHI may be shared with individuals designated to assist in conducting this case study as well as with accreditation bodies. PHI may also be reviewed to ensure that the case study meets legal and institutional standards.

Section V – Publication Rights

I understand the following with respect to publication of personal information:

- The Information will be published without my name/child's name/relative's name attached and every attempt will be made to ensure anonymity. I understand, however, that complete anonymity cannot be guaranteed. It is possible that somebody somewhere - perhaps, for example, somebody who looked after me/my child/relative, if I was in hospital, or a relative - may identify me.
- The Information may be published in a journal which is read worldwide or an online journal. Journals are aimed mainly at health care professionals and/or scientists but may be seen by many non-doctors, including journalists.
- The Information may be placed on a website.

Section VI – Withdrawal of Consent

I understand that:

- I can withdraw my consent at any time before the information has been committed to publication (online or in print), but once the Information has been committed to publication it will not be possible to withdraw the consent.
- I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in section IV.
- The authorization to use my personal information to conduct this case report (or research study) will expire at the end of the study. However, I understand that following publication, full articles or abstracts of or from the initial report may be published and continue to be published for an indefinite period of time.
- I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

Section VII – Signature

Signature: ____________________________________ Date: ____________________________

Print your name: ____

If this form is being completed by a person with legal authority to act on an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form: ____

Signature of person completing this form: ____

Describe below how this person has legal authority to sign this form:

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