

## COLUMBIA UNIVERSITY IRVING MEDICAL CENTER CASE REPORT AUTHORIZATION

I have been asked to permit the use of my medical information for a case report that may be submitted for publication or presentation at a conference. The medical information used in the case report will not include my name or any other information that will intentionally identify me. The information will be used for educational purposes within Columbia University Irving Medical Center (the "Medical Center") or for certain medical educational purposes, at national meetings of other treatment providers or for publication.

Health information for which I am authorizing use and disclosure includes:

$\square$ medical his	tory $\square$ image	s urg	gical information
□ other			
my protected he	alth information for th		on before the Medical Center may use or disclose ses. I understand that once my information is osure.
authorized by th with this case re demands or caus or right of public	e Medical Center, the eport. I release and d es of action that I may city, infringement of co	right to use, simulate and ischarge the Medical Cernow have or may hereafte	Medical Center, and to any persons or entities didisclose my health information in connection need and their faculty from any and all claims, or have for libel, defamation, invasion of privacy yother right of my or relating to any such use of s case report.
I agree that this me regarding thi		the entire agreement and	understanding between the Medical Center and
REFUSING TO	SIGN THIS AUTHOR	RIZATION. I MAY REFU	BE CONDITIONED ON MY SIGNING OR USE TO SIGN THIS AUTHORIZATION. IF I FION WILL NOT BE USED.
This Authorizati	on does not have an ex	piration date. I have a rig	tht to receive a copy of this Authorization.
following address	ss: Attn: Chief Privac	y Officer, Office for HIP.	nust be in writing and sent or delivered to the AA Compliance, Columbia University Medical 10032. My revocation will be effective upon
Patient Name			Date
	(Pleas	se print)	
Signature			_
	Patient/ Legally Aut	thorized Representative	
Provider Name	/Program/Department		