**Authorization for Medical Case Study and publication**

**For the Use of De-Identified Medical Information**

Hello. My name is <Enter your name>, I am a <researcher/physician/investigator> at West Virginia University <Add specific department or college if necessary>.

I am reaching out to you because I would like to use your medical record data for the purpose of a case study investigating <**Enter the focus of the study** (text must be bolded)>.

If you agree to the use of your medical record data for a case study, please sign this Case Study Authorization Form. Please note that you can change your mind at any time and revoke your authorization for us of the information by writing to me at: <Provide mailing address>.

**Purpose of Authorization**

Patient authorization is not usually required for case studies since they use de-identified patient health information. Some medical journals are now requiring some type of authorization by the patient. This authorization may be used when the journal requires the author obtain the patient’s permission for the use of the information for the case study. This authorization cannot be used if the diagnosis is such that it could reasonably be used to identify the patient (for example, a rare disease). This authorization may be obtained by having the patient sign this document or verbally, depending on the requirements of the publisher

Patient Name:

**1.** **WVU Entities**

I consent to and authorize West Virginia University Board of Governors on behalf of West Virginia University or its affiliated entities including, but not limited to West Virginia University Health System, Inc.; West Virginia University Hospitals, Inc.; Braxton County Memorial Hospital, Inc.; Camden-Clark Memorial Hospital Corporation d/b/a Camden Clark Medical Center; City Hospital, Inc. d/b/a Berkeley Medical Center; The West Virginia Health Care Cooperative, Inc. d/b/a Summersville Regional Medical Center,; Potomac Valley Hospital of W. Va., Inc. d/b/a Potomac Valley Hospital; Reynolds Memorial Hospital, Inc.; St. Joseph’s Hospital of Buckhannon, Inc. d/b/a St. Joseph’s Hospital; The Charles Town General Hospital d/b/a Jefferson Medical Center; United Hospital Center, Inc.; Community Health Association, d/b/a Jackson General Hospital; Wetzel County Hospital, Inc.; United Physicians Care, Inc.; West Virginia University Dental Corporation d/b/a University Health Associates—Dental Practice; West Virginia University Hospitals, Inc.; West Virginia University Hospitals—East, Inc. d/b/a University Healthcare; and West Virginia University Medical Corporation d/b/a University Health Associates; University Healthcare Physicians, Inc., (“UHP”)(collectively “WVU”) to use my health information for a medical case study. Only diagnosis and demographic information such as age, sex, and race will be used in any published case study. All other medical identifiers will be removed and not use in the case study.

**2.** **Nature AND Purpose of Disclosure**

The nature of my health information to be used is diagnosis, care, disease progression, and treatment. I understand the case study will focus on the subject listed at the top of this document. There will be no patient identifiers in the case study, and my name will not be used. I understand that the case study will be used and/or published for medical education purposes. Although my personal information collected or obtained will be kept confidential and protected to the fullest extent of the law, there is a limited risk associated with this case study that it could result in a loss of confidentiality by virtue of my unique experience.

**3.** **Re-disclosure**

I understand that WVU does not retain control over its editing or use once the case study is published.

**4. Refusal to Authorize Use and/or Disclosure**

I understand that my refusal to authorize the use of my health information for the medical case study will in no way affect my eligibility to receive medical care at any WVU health care facility.

**5. Patient Compensation**

I understand that this is voluntary and that I will receive no compensation for the use of my health information for this case study or its publication. I further understand that I will have no economic and/or intellectual property right, title or interest, or any other property right or license in the case study authorized above.

**6. WVU Compensation**

I understand that WVU will not receive financial compensation from a third party for the case study.

Signature of Patient (or Patient’s Representative) Date

Description of Authority to Act for Patient

Verbal Authorization Obtained \_\_\_\_\_\_\_\_Yes Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of WVU employee obtaining verbal authorization\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***NOTE: This form must be scanned into the patient’s medical record.***