Delivery Network/Location

NAME:

BIRTH DATE:

MRN:

DOS:

(If handwritten, patient name, MRN, birth date, and DOS)

Yale New Haven Health | Yale Medicine

Authorization for Medical Case Study and Publication

Name of Patient: _____ Date of Birth: _____

Title of Article/Thesis/Presentation: _____

Name of Publication(s) in Which Case Study Will Appear: _____

_____

Author(s): _____

Nature and extent of information to be used/disclosed in case study: _____

_____

I authorize Yale New Haven Health/Yale Medicine to use and disclose the information about me/the patient outlined above ("the information") for the purpose of a medical case study. I understand this medical case study may be published in a journal article or utilized for the purposes of a thesis or educational presentation.

I understand the following:

1. The Information will be published without any part of my name or initials being attached or included, however, I understand that complete anonymity cannot be guaranteed.
2. The Information may show (via photo or image) or include details of my/the patient's medical condition or injury and any prognosis, treatment, or surgery that I have/the patient has, had, or may have in the future.
3. The Information may be published in a journal, including an online journal, which is distributed and read worldwide.
4. The Information may be the subject of a press release and may be linked to/from social media and/or utilized in other promotional activities. Once published, the article may be placed on a website and may be available on other websites.
5. I/the patient will not receive any financial benefit from the publication of the article.
6. This authorization is voluntary, and my treatment is in no way conditioned on whether or not I sign this authorization.
7. This authorization is valid until I explicitly revoke it by contacting the author in writing.
8. I may change my mind and cancel (revoke) this authorization at any time. Cancellation or revocation will only apply to future uses or disclosures and will not apply to past publications or previous use of the information based on this authorization. Previous use or disclosure of information in accordance with this authorization may be subject to re-disclosure by the recipient and will no longer be protected under the terms of this authorization or by federal privacy regulations.

Printed Name: _____ Date: _____

_____ _____

Signature of Patient or Authorized Representative Relationship to Patient

If images of my/the patient's face or distinctive body markings are to be published, the following section should be completed in addition to the first section:

____ initial **I AUTHORIZE** images of my face or distinctive body markings to be utilized and recognize that I/the patient might therefore be identifiable, even though my name/the patient's name and initials will not be published.

OR

____ initial I **DO NOT AUTHORIZE** images of my face or distinctive body markings to be utilized.

(COPY TO PATIENT OR AUTHORIZED REPRESENTATIVE)

Delivery Network/Location

NAME:

BIRTH DATE:

MRN:

DOS:

(If handwritten, patient name, MRN, birth date, and DOS)

Yale New Haven Health | Yale Medicine

Authorization for Medical Case Study and Publication

Interpretation Services (if necessary): An interpreter facilitated the communication between the health care provider(s) and the patient or person authorized to consent for the patient in _____ (language) to assist in obtaining informed consent.

The interpreter conveyed the content of the original information expressed by and for both parties.

Time: _____ AM/PM Date: _____

Check here if: ☐ Telephone ☐ Video ☐ In person ☐ Bilingual Competency Program Approved Staff

ID Number (telephone/video only): _____

_____ Print Name of Interpreter

_____ Signature of **Interpreter (in-person only)**