Authorization to Release Health Information for Research Purposes

Doctor's Name_____

What information will be collected?

Because of the benefits you experienced under chiropractic I want to complete a case study research report and submit it for publication to a research journal. This research report will describe your experience under chiropractic care after it has already occurred. This is called a "retrospective" case study research report.

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law passed to protect the privacy of your Protected Health Information (PHI). PHI is any information about you that could tell someone else who you are. We will not use or share your health information in any way other than what we explain in this form. We will keep your health information private to the extent allowed by law. We will use a study number or other code rather than your name on study records when we can. Your name or any other fact that might point to you will not appear if we publish the study results or make a presentation about the study without your permission.

Signing this document means you allow the researchers completing the case study to use your health information for this retrospective case study and submit it for publication. If needed your doctor will make copies of your health records to construct the report. In such a case, all protected health information in your records will be redacted or blacked out including:

- ☐ Name
- ☐ Address
- ☐ Telephone #
- ☐ Date of Birth
- ☐ Social Security #
- ☐ Fax #
- ☐ Medical Record #
- ☐ Account #
- ☐ Email or IP address
- ☐ Dates of admission, discharge, treatment or death
- ☐ Health Plan #'s
- ☐ Full face photogenic images or comparable images
- ☐ Certificate/License #'s
- ☐ Vehicle Identifiers, vehicle serial #'s or license plate #'s
- ☐ Device Identifiers and serials #'s
- ☐ Biometric identifiers, including finger and voice prints

It is your choice to let us use your health information. You can, at any time, change your mind about us using your health information. You will receive a copy of this form.

_____
Print Patient Name

_____
If Minor Printed Name of Parent or Legal Guardian
Check one of the following: ☐ I am the parent ☐ I am the Legal Guardian

_____ _____
Signature of Parent, Legal Guardian or Patient Date

_____
Printed Name of Person Obtaining Authorization (Field Doctor)

_____ _____
Signature of Person Obtaining Authorization (Field Doctor Date