M20UP-085
Rev. 12/20

DukeHealth

AUTHORIZATION TO USE OR DISCLOSURE PROTECTED HEALTH INFORMATION FOR MEDICAL EDUCATION PURPOSES

Place Patient Label Here

Authorization to Use or Disclosure Protected Health Information for Medical Education Purposes

I _____, am the patient / or authorized personal representative to authorize Duke University, Duke University Health System, the Private Diagnostic Clinic and other members of the Duke Health Enterprise identified in its Notice of Privacy Practices (collectively "Duke"), as well as any duly authorized affiliates, subsidiaries and physicians to use, disclose, store and archive materials and health information pertaining to me/the patient described below for medical education intended for medical professionals.

Part A: Patient Information

Patient Name: Date of Birth: Phone #:

Address:

Part B: Health Information

I approve the following, specific materials and health information for Duke to use, disclose, store or archive for medical education purposes: *Please mark the spaces/boxes below for the information you explicitly approve.*

☐Demographic information such as, name, age, city/county and state of residence

☐Specific diagnosis and treatment information, including treatment date(s), provider name(s) and treatment location(s)

☐Redacted medical images, photos, scans with direct patient identifers removed **Note: direct patient identifers, such as your name and medical record number, will be redated or removed (unless you otherwise specifically permit), but other indirect identifiers, such as date of service, or unique physical or clinical characteristics, may still remain in the image, photo, scan.*

☐Exceptions/special instructions: *please explain*

_____

Part C: Educational Activities & Purposes

I agree that the health information identified specific to my condition may be used, disclosed, stored or archived for educational activities including: *Please mark the spaces/boxes below for the activities and purposes you explicitly approve.*

□ Publication in scientific journals, clinical articles, books, and their related websites and online media channels.

□ Clinical medical education presentations, including classroom and virtual instruction, medical training at Duke, community education events, other academic institutions, and/or professional national and international conferences or other professional or education events and their related printed and online communication channels, such as websites and social media.

Part D: Review & Approval

I understand that once the materials and health information identified above are publicly used or disclosed as provided in this authorization, Duke may not retain control over the further use or disclosure of these materials and health information by any third party and also that these materials and information may no longer be protected by federal or state privacy law. In particular, I understand that, after publication and/or distribution, these materials and health information may be picked up, reprinted and/or rebroadcast and disclosed by other people or entities who are not connected to Duke.

Duke cannot limit the amount of times other people or entities may use footage for future print or online publications or broadcast, rarely has final control over the use or (re)distribution of such materials, and cannot guarantee that other entities will not capture and display on their own website or other communications platforms that I have authorized to be disclosed by Duke above, despite Duke's copyright.

DukeHealth

AUTHORIZATION TO USE OR DISCLOSURE PROTECTED HEALTH INFORMATION FOR MEDICAL EDUCATION PURPOSES

Place Patient Label Here

I understand that I will receive no compensation from Duke for this authorization or for anything described herein. I also understand that my health care treatment or payment for health care services at Duke is not conditioned upon my giving this authorization. I have read this form and fully understand the contents. I agree to be bound by this authorization. I acknowledge and represent that I am the patient whose health information is the subject of this authorization and that I am 18 years of age or older or that I am the personal representative of the patient whose health information is the subject of this authorization.

This authorization for Duke's purposes expires at the termination of the last of the educational activities described above in which I have agreed to participate. Specifically, the termination date occurs at the conclusion of the last activity that includes the above described materials and my health information.

I may revoke this authorization at any time, which I must provide in writing and send to _____. I understand this revocation will not affect any uses or disclosures prior to such revocation. I understand I may review or obtain a copy of the health information subject to this authorization by making a request in writing and sending it to the address above.

_____ _____
Signature of Patient/Personal Representative Date/Time

_____ _____
Printed Name Relationship to Patient

A signed copy of this form will be provided to patient or personal representative at the time of execution.