**We are asking you to let us use and share {your photograph and} information about your medical condition and treatment for a medical journal case report.**

* You recently received treatment at Boston Medical Center for *{name of condition}*. {*Author/doctor*} and the other doctors involved in your care would like to submit *{your photograph and}* information about your diagnosis, treatment and follow-up to a medical journal: *{name of journal}*. The purpose is to inform and teach other doctors. The journal is published in print and on the internet.

**What is in the case report** *{****and photograph}*?**

* *{The picture will show your condition.}* The case report will describe your condition and discuss your health and treatment, including prior health history, present complaints, and laboratory and diagnosis facts. You will receive no payment for being in the case report.
* We will not use your name on our case report *{or on the pictures that we put in the case report}.* But, *{if your face can be seen or}* if you have shared your medical story, people who know you may be able to tell who you are.The people who publish the journal will know your name because they require us to give them a copy of this form. They want to be sure that a person in a journal article has given permission. However, they won’t tell anyone else your name.

**Privacy of your health information.**

* Federal and state law require BMC work force, staff, or health professionals to keep health information confidential. The federal Privacy Rule may not protect health information that you permit us to share with people outside of BMC.

**Letting us use and share your information is voluntary.**

* Your participation is completely up to you. You do not have to agree to let us use or share your *{pictures or}* medical information. Your decision (either yes or no) will not affect your being able to get health care at BMC or payment for your health care. It will not affect your enrollment in any health plan or benefits you can get. Your permission will last until BMC sends the final version of the article to the journal.

**You have the right to take back your authorization.**

Write to: BMC Director of Medical Records

Boston Medical Center

One Boston Medical Center Place

Boston, MA 02118

If you take back your authorization, it will not affect any actions we took before we received your letter.

**If you sign this form, you are agreeing to let BMC and your doctors use or give out your health information as described above**.

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship (if not patient): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**