Albany Med Health System
HIPAA Authorization for Use and Disclosure
of Protected Health Information in a Case Report

Case Report: Formation of Calculi Adherent to Vaginal Mesh Exposure in the Setting of Hyperaldosteronism: A Case Report and Review of the Literature

Principal Case Author: Katherine Husk, MD

Contact Phone Number: (518) 262-4942

MRN#: [redacted] Sex: F DOB: [redacted]
Name: [redacted]
Phy: Husk MD, Katherine E
Loc: Clinic 391 Myrtle Ave Ste 2A Dept Abbr: OBGAUROG
Plan 1: Medicare Part B Plan 2: BC Empire Blue Cross
Enc: 844000060 Other:
DOS: 07/09/2021 Time: 09:30 am Ack: 09:52 am

Introduction
If you are a parent or guardian of a patient under the age of 18, "you" means "your child." If you are the authorized representative of an adult patient, "you" means the patient on whose behalf you are acting with respect to this Authorization.

You are being asked to consider allowing Dr. Husk and one or more selected colleagues at Albany Med ("the co-authors") to use protected health information about your stone formation overlying the vaginal mesh exposure in the setting of hyperaldosteronism to write and publish or present what is called a case report.

Why Write a Case Report?
Dr. Husk believes your experience – or "case" -- as a patient with this condition would help teach other healthcare providers about the signs, symptoms, course and treatment of stones or calculi that form over mesh exposure, particularly in individual's that are at increased risk of kidney stones. Case reports are typically used to share new, unusual or otherwise notable aspects of one patient's case that may be helpful for other healthcare providers and their patients. A case report may be published and/or presented at a professional or academic conference. The case report authors may receive some professional recognition for sharing this knowledge.

What is this Form for?
This form contains information you need in order to understand how your protected health information would be used for the proposed case report and shared with others who read it or attend a presentation about it. It also informs you about your privacy rights. Please read this form carefully, ask any questions you may have, and take your time to decide. If you decide to give your permission, you will find a place at the end of this form to print your name and provide your signature and the date.

Which Information Would be Used?
If you give your permission, Dr. Husk and/or the co-authors would access your medical record and collect some information from it, including your age, medical conditions, lab results, intraoperative photo images (of the mesh with overlying stone), and treatment history. They would then use this information to write a summary of your "case," including symptoms, treatment, and outcome, for example.

How Would My Information Be Shared and My Privacy Protected?
In writing the case report, to the greatest extent possible, your privacy would be protected by not

including information that would individually identify you. For example, your name, date of birth, address, medical record number, and similar identifying information would not appear. Any notes or drafts containing your identifiable information would be stored and disposed of securely. The case report would be submitted to journals or presentation organizers for consideration. If selected, the case report would then be shared with journal readers or people attending the presentation.

Please understand that the unusual aspect of your case could lead someone familiar with you or your treatment (such as a doctor or nurse who took care of you) to identify you in the case report even if your name, address, etc, are not included. For this reason, federal privacy rules may not protect your health information once the case report has been published or presented, and complete anonymity cannot be guaranteed. Your identifying information, including the unusual aspect of your case, may be used in the case report only if you grant permission by signing this form.

Other Important Notes

You have the right to revoke your authorization in writing. If you decide to revoke, you may write to Dr. Husk at 391 Myrtle Ave., Suite 200, Albany, NY, 12208. However, if you change your mind after the case report is written and shared, it will not be possible to revoke your authorization.

Albany Med may not condition treatment, payment, enrollment or eligibility for benefits on your decision whether or not you sign this form. If you choose to sign this form, Albany Med must give you a copy. Allowing your information to be used in the case report will not result in any additional cost to you or payment to you. This Authorization, if signed, expires upon publication or presentation of the case report.

If you have any questions, please contact that Albany Medical Center Institutional Review Board at (518) 262-5997.

HIPAA AUTHORIZATION

Your signature shows that you allow your protected health information to be collected, used and shared as described in this form.

PATIENT

[redacted]

Print Patient Name [redacted]

Signature [redacted]

Date Signed 7/9/2021

Time Signed 10:37

Relationship of Person Signing for Patient:

☑ **Self**

☐ **Parent/Guardian (print name):**_____

☐ **Healthcare Agent/Power of Attorney (print name):**_____

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