

**AUTHORIZATION FOR MEDICAL CASE STUDY AND PUBLICATION
DE-IDENTIFIED MEDICAL INFORMATION**

PURPOSE OF AUTHORIZATION

PATIENT AUTHORIZATION IS NOT USUALLY REQUIRED FOR CASE STUDIES SINCE THEY USE DE-IDENTIFIED PATIENT HEALTH INFORMATION. SOME MEDICAL JOURNALS ARE NOW REQUIRING SOME TYPE OF AUTHORIZATION BY THE PATIENT. THIS AUTHORIZATION MAY BE USED WHEN THE JOURNAL REQUIRES THE AUTHOR OBTAIN THE PATIENT'S PERMISSION FOR USE OF THE INFORMATION FOR THE CASE STUDY. THIS AUTHORIZATION CANNOT BE USED IF THE DIAGNOSIS IS SUCH THAT IT COULD REASONABLE BE USED TO IDENTIFY THE PATIENT (FOR EXAMPLE A RARE DISEASE) THIS AUTHORIZATION MAY BE OBTAINED BY HAVING THE PATIENT SIGN THIS DOCUMENT, OR VERBALLY, DEPENDING ON THE REQUIREMENTS OF THE PUBLISHER

Patient Name: [REDACTED] Mailing address: [REDACTED]
City: NASHIK State: MAHARASHTRA Phone: [REDACTED]

1. HCG MANAVATA ONCOLOGY LLP ENTITIES

I consent to and authorize HCG Manavata Oncology LLP or its affiliated entities including, but not limited to HCG Manavata Cancer Centre (collectively "HCG Manavata") to use my health information for a medical case study. Only diagnosis and demographic information such as age, sex and race will be used in any published case study. All other medical identifiers will be removed and not use in the case study.

2. NATURE AND PURPOSE OF DISCLOSURE

The nature of my health information to be used is diagnosis, care, disease progression, and treatment. I understand the case study will focus on MALIGNANT EPIDERMID ARISING FROM 3rd VENTRICLE. There will be no patient identifiers in the case study and my name will not be used. I understand the case study will be used and/or published for medical education purposes.

3. RE-DISCLOSURE

I understand that once the case study is published HCG MANAVATA does not retain control over its editing or use.

4. REFUSAL TO AUTHORIZE USE AND/OR DISCLOSURE

I understand that my refusal to authorize the use of my health information for the medical case study will in no way affect my eligibility to receive medical care at any HCG Manavata health care facility.

5. PATIENT COMPENSATION

I understand that this is voluntary and that I will receive no compensation for the use of my health information for this case study or its publication. I further understand that I will have no economic and/or intellectual property right, title or interest, or any other property right or license in the case study authorized above.

6. HCG MANAVATA COMPENSATION

I understand that HCG Manavata will not receive financial compensation from a third party for the case study.

Signature of Patient (or Patient's Representative) [REDACTED] Date 12-FEB-2019

Description of Authority to Act for Patient _____

Verbal Authorization Obtained Yes Date 12-FEBRUARY 2019
Name of HCG Manavata employee obtaining verbal authorization [REDACTED]

NOTE: This form must be scanned into the patient's medical record. Form specially prepared for case study using de-identified patient information.