The Jikei University University School of Medicine
Authorization Form for Publication or Presentation of an Identifiable Case Report

Title of case report:
Liver injury after aluminum potassium sulfate and tannic acid treatment of hemorrhoids

Author: Kenichi Yoshikawa

Patient's Name: Kazuhiro Saitoh

Please Note: "You" refers to the patient about whom the case report is written.

We know that information about you and your health is private. We are dedicated to protecting the privacy of that information. We would like to describe what happened during part of your care in a "case report." A case report is a short description of details about your illness or treatment. The purpose of a case report is to let other health care providers or researchers learn. It could be published in a medical journal or described at a medical meeting. Typically, it does not include your name or any other information that can directly identify you, however it is necessary in this instance for the case report to directly or indirectly identify you.

Because of this promise to protect your privacy, we must get your written authorization (permission) before we may use, disclose, or share your identifiable information. This form gives us that permission. It also helps us make sure that you are correctly told how this information will be used or disclosed. Please read the information below carefully before signing this form. Please ask any questions you may have about this form or its uses. You can decide to sign or not to sign this form. If you choose not to give your permission and do not sign this form, then your information cannot be used. Whatever choice you make, it will not have an effect on your medical care.

USE AND DISCLOSURE COVERED BY THIS AUTHORIZATION

DO NOT SIGN A BLANK FORM. *You or your authorized representative should thoroughly read the information below before signing this form.*

Who will disclose, receive, and/or use the information? This form will authorize the following person(s), class(es) of persons, and/or organization(s) to disclose, use, and receive the information:

- The authors of the case report listed above.
- The editorial staff of the medical journals or meeting staff of conferences where the case report will be published or presented.
- Anyone (usually health care providers and researchers) reading the journal or attending the meeting.

- The members and staff of any Institutional Review Board (IRB) that oversees this research study.

What information will be used or disclosed?

- Identify the section(s) of the research and/or medical record to be used or disclosed. Only the minimum necessary information required to describe the case may be used or disclosed.(e.g. all medical records and clinic notes from May 2000-December 2000, or medical records related to the diagnosis/treatment of ____ condition in 2010.) The information to be used or disclosed is to be listed in the CRAF. The language must be simple, in lay terms, and at an 8th grade reading level.

- The following images and/or results: (*e.g.*, "laboratory results from July 2002," "all laboratory results," or "results of MRI performed in July 2002.")

- The following identifiable information: (e.g. name, dates, identifiable photographs or other images, unique personal details, or specific details related to your treatment or condition that are unique and may be identifiable)

SPECIFIC UNDERSTANDINGS

By signing this case report authorization form, you give permission for the use and/or disclosure of your protected health information and the identifying information described above. The purpose for the uses and disclosures you are authorizing is to allow the publication or presentation of the case report. This information may be re-disclosed or used for other purposes if a recipient described in this form is not required by law to protect the privacy of the information.

You have a right to refuse to sign this authorization. Your health care, the payment for your health care, and your health care benefits will not be affected if you do not sign this form.

If you sign this authorization, you will have the right to cancel it at any time. However, if the case report has already been published or presented, this cannot be undone. If you withdraw permission before the case report is presented or published, we will stop the case report from being published or presented. This authorization will never expire until and unless you cancel it. To cancel this authorization, please write to the HIPAA Privacy Officer for Research at: 800 Washington Street, Box 451, Boston, MA 02111.

You have a right to receive a copy of this form after you have signed it.

THE PATIENT OR HIS/HER LEGALLY AUTHORIZED REPRESENTATIVE MUST BE PROVIDED WITH A COPY OF THIS FORM AFTER IT HAS BEEN SIGNED.

SIGNATURE

I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above.

Kazuhiro Saitoh

Print Name of Patient or Authorized Representative

24th March, 2017

Date