DREXEL UNIVERSITY COLLEGE OF MEDICINE

Consent and Release Form for Use of Protected Health Information

1. General Description. Thank you for agreeing to our request to participate in the education and training of our medical students and residents. This form provides information about how we may use and disclose protected health information (PHI) about you for these purposes. We are asking you to read and sign this form so that we can comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This form summarizes the anticipated use of your interview and PHI for which your authorization is required.

2. Specific description of the information to be used or disclosed, including the specific purpose:

I understand and consent that my PHI will be discussed and disclosed during (check one that applies):

_____ my participation in a live lecture held on _____, 20_____ which will not be recorded or filmed.

_____ the recording or filming of my participation in the live lecture held on _____, 20_____

_____ the recording or filming of my interview and/or physical examination with Dr. _____ that occurred on _____, 20_____.

I understand that this disclosure may include information about my medical history, symptoms and condition, and that I consent to the disclosure of this information **including any information about my mental health, drug or alcohol abuse or dependence, HIV related information, genetic information and sexual assault counseling that may arise**. I also understand that my name and physical identity will not be concealed in any lectures or recordings**.**

3. Individuals who may use or disclose this information: Faculty, employees, agents and students of Drexel University, and healthcare professionals, educators and students outside of Drexel University.

4. Individuals who may receive and use the disclosed information: Students, medical residents, physicians, faculty members and employees in the course of educational, research or training programs offered by Drexel University. Also, this will be shown and used by the public outside of Drexel University for training, educational, or research purposes.

5. Consent to publication and distribution in any form: I understand and consent to this use, publication and distribution in any media, now known or hereafter developed, including without limitation, videotape and sound recording. In addition to the Protected Health Information, this includes me and my image, my name, likeness, words and biographical material about me and my family. I transfer any copyrights I may have in the publication.

6. Release of Liability: I voluntarily release and hold harmless Drexel University, its trustees, officers, faculty, employees, students and agents from any and all claims, causes of action, injuries, damages or losses of any kind that may arise from my participation in the recording, use and disclosure described in this Consent and Release.

7. Expiration date of this authorization: I can decide at any time during the interview or examination that I want the recording to stop. If I decide later that I want Drexel University to stop using my photograph or recording, I can revoke this consent by writing to the address below. Upon receiving this written notice, Drexel University will cease all use of my photograph or recording except in circumstances where it has already taken action in reliance on this consent. I understand that it may have already published my recording at that time, and will be unable to recall the publication.

8. No compensation: I understand I will not receive any payment or any other type of compensation for the use of my photograph or recording.

9. Re-disclosure: The above mentioned protected health information may be subject to re-disclosure by the party receiving the information and may no longer be protected by the privacy rules.

10. Understanding and Legally Bound: I am signing this Consent and Release with an understanding of its contents and with the intention to be legally bound by it. By signing this form in the space provided below, I authorize Drexel University to the use and disclosure of the contents of the interview and protected health information about me for the reasons mentioned above.

This authorization was signed by: _____

Please Print Name: _____

Date: _____

Authorized Representative: _____

Printed Name of Authorized Representative: _____

Inquiries:

Chief Compliance and Privacy Officer
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