**HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (“HIPAA”)**

**AUTHORIZATION TO USE OR DISCLOSE**

**PROTECTED HEALTH INFORMATION**

**Patient Name:**

**Patient ID Number:**

**Protocol Name and Number (If Appropriate):**

***We understand that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must******obtain your written authorization before we may use or disclose information about you and the healthcare that you receive. This form provides that authorization and helps us make sure that you are properly informed about how this information will be used and disclosed. Please read the information below carefully before signing this authorization.***

**USE AND DISCLOSURE COVERED BY THIS AUTHORIZATION**

As you are aware, the ***[INSERT NAME OF PROCEDURE – for example: Percutaneous Transluminal Coronary Angioplasty]*** you will be undergoing on ***[INSERT DATE OF PROCEDURE]*** is going to be transmitted live and presented as a “Live Case” at the Transcatheter Cardiovascular Therapeutics Meeting of 2014 (“TCT 2014”). As described in more detail below, your procedure will be viewed and discussed by the faculty and people attending TCT 2014 at the *Walter E. Washington Convention Center* in Washington, D.C., and elsewhere around the world via remote viewing capabilities, such as an Internet webcast. In addition to the live viewing, your procedure will be recorded, and this recording will maintained and disseminated to the general public by the Cardiovascular Research Foundation (“CRF”) – the medical research foundation that presents the Transcatheter Cardiovascular Therapeutics Meeting.

**Who will use or disclose the information?**

By signing this Authorization to Use or Disclose Protected Health Information, you authorize and grant permission to ***[INSERT NAME OF HOSPITAL]***, the site at which the procedure will be performed, and CRF, and their respective employees, agents, contractors, licensees, successors and assigns, to use and/or disclose your health information as described in this authorization.

**The health information that will be used or disclosed includes:**

Photographs or video taken of you (which may include your face or other identifiable characteristics) during the course of your procedure, as well as any information necessary to explain the photographs or video, and any clinical information contained in your medical records (including your medical history) or research study files.

**What is the purpose of the use or disclosure authorized by this form?**

The information described above will be used and disclosed for educational, commercial, marketing and informational purposes, including as follows:

* The transmission of a live showing of the ***[INSERT NAME OF PROCEDURE]*** that you will be undergoing on ***[INSERT DATE OF PROCEDURE]*** to TCT 2014. The procedure will be presented as a Live Case and viewed by the people in attendance at TCT 2014, whether in person or via remote viewing capabilities (such as Internet webcast, television broadcast, etc.) in real-time format.
* The filming, taping and recording of your procedure for later use and disclosure by *[INSERT NAME OF HOSPITAL AND]* CRF, including, but not limited to, the inclusion of the recording of your procedure in videocassettes, CDs or DVDs disseminated to the general public, posting the recording on the Internet where it will be viewed by the general public, or including it in or on other media or formats.
* The distribution, circulation or presentation, either by itself or with other written, printed, graphic, digital, audio, video or other materials, of information produced, transmitted and/or recorded during TCT 2014, including your procedure, to medical professionals, device manufacturers, and other members of the general public.
* Publication of your procedure in other publications or presentations (in addition to TCT 2014) prepared by CRF for dissemination to the general public.
* Posting to and dissemination of your procedure on public websites.

CRF may charge a fee or receive some other type of compensation in connection with these purposes.

**Who will use or receive the information?**

The general public, including, but not limited to, the following:

* The attendees of TCT 2014, including those who will be viewing the conference, and your procedure specifically, remotely around the world, such as via the Internet or through a video or television transmission.
* Individuals accessing websites where images from TCT 2014, including your procedure, may be displayed.
* Any and all consumers/recipients of any videocassettes, CDs, DVDs or other related video media, produced, distributed, circulated, presented and/or disseminated by CRF which contain your health information, whether alone or in conjunction with other matter, such as written, printed, graphic, or audio matter.
* CRF and CRF’s employees, agents, contractors, licensees, customers, successors, and assigns.

**When will this authorization expire?**

This authorization will expire ten (10) years from the date on which your procedure is performed.

**Can I revoke this authorization?**

You have a right to revoke your authorization at any time before *[INSERT NAME OF HOSPITAL]* or CRF has relied on it. Reliance on your authorization begins as soon as the filming of your procedure begins. After filming begins, you may no longer revoke this authorization, as *[INSERT NAME OF HOSPITAL]*, CRF, and their contractors, agents, licensees and others will incur substantial expenses in reliance on your authorization.

To revoke your authorization, you must send a notice in writing to *[INSERT NAME AND CONTACT AT HOSPITAL]* – stating that you are revoking your Authorization to Use or Disclose Protected Health Information.

**SPECIFIC UNDERSTANDINGS**

By signing this authorization, you authorize the use or disclosure of your health information as described above. You should note that when your health information is disclosed to people or entities who are not required to abide by the federal, state and local medical privacy laws, those people or entities may re-disclose the health information to others and may use your health information in ways other than those listed in this authorization without being subject to penalties under those laws.

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 authorization.

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

By signing this authorization you also understand, acknowledge and agree that CRF will have and may exercise all rights of whatever kind or nature in the recording of your procedure that now or may thereafter be protected by the copyright laws of the United States of America, any other applicable federal or state laws and the applicable laws of all foreign countries.

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***I have read this HIPAA Authorization to Use or Disclose Protected Health Information and all of my questions about it have been answered. By signing below, I acknowledge that I have read, understand and accept all of terms and conditions set forth in this Authorization to Use or Disclose Protected Health Information, and am signing of my own free will***.

Signature of Patient or Personal Representative

Print Name of Subject or Personal Representative

Date

Description of Personal Representative’s Authority **[*If Applicable*]**

***[Please note: If signed by a legal representative, you must include on this page a description of the representative's authority to act on the individual's behalf.]***

***THE PATIENT OR HIS OR HER PERSONAL REPRESENTATIVE MUST BE PROVIDED WITH A COPY OF THIS AUTHORIZATION AFTER IT HAS BEEN SIGNED.***