Health Care Provider(s) or Other Entity

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Study Title

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Sponsor/Funding Agency (if funded) Principal Investigator Name IRB ID

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1. **What is the purpose of this form?**

State and federal privacy laws protect the use and release of your private personal identifiable health information, including those protections ensured by the Health Information Portability and Accountability Act (HIPAA). Under these laws, the above-named health care providers or other entities cannot release your health information to the research team unless you give your permission. The research team includes the researchers and other people hired to do the research. If you decide to give your permission and to participate in the study, you must sign this form as well as the Consent Form. This form describes the different ways that the researcher, research team and research sponsor may use your health information for the research study. The research team will use and protect your information as described in the Consent Form.

However, once your health information is released it may not be protected by the privacy laws and might be shared with others. If all information that does or can identify you is removed from your health information, the remaining information will no longer be subject to this authorization and may be used or disclosed for other purposes. If you have questions, ask a member of the research team.

1. **What Personal Health Information will be released?**

If you give your permission and sign this form, you are allowing the above-named health care providers to release the following medical records containing your private Personal Health Information. Your private Personal Health Information includes health information in your medical records and information that can identify you. For example, private Personal Health Information may include your name, address, phone number or social security number.

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| [ ]  Entire Medical Record | [ ]  Laboratory Reports | [ ]  Emergency Medicine Reports |
| [ ]  Outpatient Clinic Records | [ ]  Dental Records | [ ]  Health Billing Statements |
| [ ]  Pathology Reports | [ ]  Operative Reports | [ ]  Diagnostic Imaging Reports |
| [ ]  EKG | [ ]  Radiology Reports | [ ]  History & Physical Exams |
| [ ]  Progress Notes | [ ]  Radiologic & MR Scans | [ ]  Consultations |
| [ ]  Discharge Summary | [ ]  Psychological Tests |  |

Other (describe)

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1. **Do I have to give my permission for certain specific uses?**

Yes. The following information will only be released if you give your specific permission by putting your initials on the line(s). <Delete or otherwise disable such as with a strike through any parts of this section if they do not apply to this project>

\_\_\_\_\_ I agree to the release of information pertaining to drug and alcohol abuse, diagnosis or treatment.

\_\_\_\_\_ I agree to the release of HIV/AIDS testing information.

\_\_\_\_\_ I agree to the release of genetic testing information.

\_\_\_\_\_ I agree to the release of information pertaining to mental health diagnosis or treatment as follows

1. **How will my private Personal Health Information be used?**

Your private Personal Health Information may be released to these people for the following purposes

1. To the research team for the research described in the attached Consent Form;
2. To individuals who are required by law to review the research;
3. To others who are required by law to review the quality and safety of the research, including: U.S. government agencies, such as the Food and Drug Administration, the research sponsor or the sponsor’s representatives, or government agencies in other countries. These organizations and their representatives may see your Personal Health Information. They may not copy or take it from your medical records unless permitted or required by law.
4. **How will my private Personal Health Information be used in a research report?**

If you agree to be in this study, the research team may fill out a research report. (This is sometimes called “a case report” or “research data”.) The research report will **not** include your name, address, or telephone or social security number. The research report may include your date of birth, initials, dates you received medical care, and a tracking code. The research report will also include information the research team collects for the study. The research team and the research sponsor may use the research report and share it with others in the following ways:

1. To perform more research;
2. Share it with researchers in the U.S. or other countries;
3. Place it into research databases;
4. Use it to improve the design of future studies;
5. Use it to publish articles or for presentations to other researchers;
6. Share it with business partners of the sponsor; or
7. File applications with U.S. or foreign government agencies to get approval for new drugs or health care products.

To maintain the integrity of this research study, you generally will not have access to your personal health information related to this research until the study is complete. If it is necessary for your care, your health information will be provided to you or your physician or other healthcare provider.

1. **Does my permission expire?**

This permission to release your private Personal Health Information expires when the research ends and all required study monitoring is over. Research reports/data can be used forever

1. **Can I cancel my permission?**

You can cancel your permission at any time. You can do this in two ways. You can write to the researcher or you can ask someone on the research team to give you a form to fill out to cancel your permission. If you cancel your permission, you may no longer be in the research study. You may want to ask someone on the research team if canceling will affect your medical treatment. If you cancel, information that was already collected and disclosed about you may continue to be used. Also, if the law requires it, the sponsor and government agencies may continue to look at your medical records to review the quality or safety of the study.

1. **Signatures**

**Subject**

If you agree to the use and release of your Private Personal Identifiable Health Information, please print your name and sign below. You will be given a signed copy of this form.

Subject’s Name (print)

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Subject’s Signature Date

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**Parent or Legally Authorized Representative (where IRB approved)**

If you agree to the use and release of the above-named subject’s Private Personal Identifiable Health Information, please print your name and sign below.

Parent or Legally Authorized Representative’s Name (print) Relationship to the Subject

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Parent or Legally Authorized Representative’s Signature Date

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**Person Obtaining Permission/Authorization**

Name (print)

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Signature Date

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