###### AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION FOR RESEARCH

###### Name of Research Study: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IRB Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Subject’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We want to use your private health information in this research study. This will include both information we collect about you as part of this study as well as health information about you that is stored in your medical record. The law requires us to get your authorization (permission) before we can use your information or share it with others for research purposes. You can choose to sign or not to sign this authorization. However, if you choose not to sign this authorization, you will not be able to take part in the research study. Whatever decision you make about this research study will not affect your access to medical care.

###### Section A:

###### I authorize the use or sharing of my health information as described below:

**Who will be asked to give us your health information:**

*Individual Releasing PHI\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_ Initial \_\_\_\_\_\_\_*

Who will be able to use your health information for research:

* *The researchers and research staff conducting this study at name the institution*
* *Research teams at other institutions: name the other institutions*

**Section B: Description of information:**

**(1) If you choose to be in this study, the research team needs to collect information about you and your health. This will include information collected during the study as well as information from your existing medical records from *{enter beginning date}* through {*enter ending date or event such as the end of the study, if known}***

**Your health information will be used and shared with others for the following study-related purpose(s):**

* ***Find out study eligibility (screening)***
* ***Data analysis of results***
* ***Study audit and oversight***
* ***Establish {tissue or data, blood sample, or DNA} repository***
* ***Other {Describe or list other purposes as appropriate from protocol}***

**(2) Specific description of information we will collect: *indicate the health information you will collect during the research and from medical records. Delete the items that do not pertain.***

* ***problem list***
* ***medication list***
* ***list of allergies***
* ***immunization records***
* ***most recent history***
* ***most recent discharge summary***
* ***lab results {describe the dates or types of lab tests you would like disclosed}***
* ***x-ray and imaging reports {describe the dates or types of x-rays or images you would like disclosed}***
* ***consultation reports from {please supply doctors' names}***
* ***entire record***
* ***other {please describe}***

***(3) We will also request the following specific items: check the ones you’ll need and delete the others.***

*\_\_\_\_****Psychotherapy/Mental Health Communications*** *(psychiatrist; psychologist; clinical nurse specialist; marriage, family, rehabilitation, and mental health counselors; and educational psychologist)*

*\_\_\_\_* ***Alcohol/ Drug Abuse Treatment*** *\_\_\_\_* ***Rape Victim Counseling***

*\_\_\_\_* ***Social Worker Communications*** *\_\_\_\_* ***Domestic Violence Counseling***

*\_\_\_\_* ***Sexually Transmitted Diseases*** *\_\_\_\_* ***HIV/AIDS***

*\_\_\_\_* ***other reportable infections diseases \_\_\_\_ Genetic Testing***

**Section C: General**

1. **Expiration:**

***This authorization expires at the end of the study. Please change if the authorization has an actual expiration date.***

1. **Right To Revoke:**

**You may revoke (take back) this authorization at any time. To do this, you must ask {name of Principal Investigator} for the names of the Privacy Officers at the institutions where we got your health information. You must then notify those Privacy Officers in writing that you want to take back your Authorization. If you do, we will still be permitted to use and share the information that we obtained before you revoked your authorization but we will only use and share your information the way the Informed Consent Form says.**

1. **If you revoke this authorization, we may still need to share your health information if you have a bad effect (adverse event) during the research.**
2. **Your Access to the Information:**

**You have the right to see your medical records, but you will not be allowed to review medical records in your research records until after the study is completed.**

**…………………………………………………………………………………………………..**

**I have read this information, and I will receive a signed copy of this form.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of research subject or personal representative Date**

**Printed name of personal representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship to research subject: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Please describe the personal representative’s authority to act on behalf of the subject:*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_