AUTHORIZATION TO USE OR DISCLOSE (RELEASE) HEALTH INFORMATION THAT IDENTIFIES YOU FOR A RESEARCH STUDY

If you sign this document, you give permission to [name or other identification of specific health care provider(s) or description of classes of persons, e.g., all doctors, all health care providers] at [name of covered entity or covered entities] to use or disclose (release) your health information that identifies you for the research study described here:

[Provide a description of the research study, such as the title and purpose of the research.]

The health information that we may use or disclose (release) for this research includes [complete as appropriate]:

[Provide a description of information to be used or disclosed for the research project. This may include, for example, all information in a medical record, results of physical examinations, medical history, lab tests, or certain health information indicating or relating to a particular condition.]

The health information listed above may be used by and/or disclosed (released) to:

[Name or class of persons involved in the research; i.e., researchers and their staff]

[Name of covered entity] is required by law to protect your health information. By signing this document, you authorize [name of covered entity] to use and/or disclose (release) your health information for this research. Those persons who receive your health information may not be required by Federal privacy laws (such as the Privacy Rule) to protect it and may share your information with others without your permission, if permitted by laws governing them.

Where a covered entity conducts the research study, the Authorization must list ALL names or other identification, or ALL classes, of persons who will have access through the covered entity to the Protected Health Information (PHI) for the research study (e.g., research collaborators, sponsors, and others who will have access to data that includes PHI). Examples may include, but are not limited to the following:

Data coordinating centers that will receive and process PHI;
Sponsors who want access to PHI or who will actually own the research data; and/or
Institutional Review Boards or Data Safety and Monitoring Boards.

If the research study is conducted by a covered entity other than the covered entity, the authorization need only list the name or other identification of the outside researcher (or

class of researchers) and any other covered entity to whom the covered entity is expected to make the disclosure.

Please note that [include the appropriate statement]:

You do not have to sign this Authorization, but if you do not, you may not receive research-related treatment.

[Name of covered entity] may not condition (withhold or refuse) treating you on whether you sign this Authorization.

Please note that [include the appropriate statement]:

You may change your mind and revoke (take back) this Authorization at any time, except to the extent that [name of covered entity(ies)] has already acted based on this Authorization. To revoke this Authorization, you must write to: [name of the covered entity(ies) and contact information].

You may change your mind and revoke (take back) this Authorization at any time. Even if you revoke this Authorization, [name or class of persons at the covered entity involved in the research] may still use or disclose health information they already have obtained about you as necessary to maintain the integrity or reliability of the current research. To revoke this Authorization, you must write to: [name of the covered entity(ies) and contact information].

This Authorization does not have an expiration date [or as appropriate, insert expiration date or event, such as "end of the research study."]

_____
Signature of participant or participant's personal representative

_____
Date

_____
Printed name of participant or participant's personal representative