Authorization To Use Your Health Information For Research Purposes

1. Introduction:

Because information about you and your health is personal and private, it generally cannot be used in this research study without your written authorization. The form is intended to inform you about how your health information will be used or disclosed in the study. Your information will only be used in accordance with this authorization form and the informed consent form and as required or allowed by law. Please read it carefully.

2. What is the purpose of this research study and how will my health information be utilized in the study?

The purpose is to collect basic patient demographics, self-administered questionnaires, surgical data, related physical examination records, and x-rays in a password secured data base, in order to answer research questions posed by the investigator in regards to outcome of total joint replacement.

None of the patients' individual responses or identifiers are ever used in publications. Instead patient responses remain anonymous and are aggregated as a group.

3. Do I have to agree to this authorization?

You do not have to agree to this authorization. But if you do not, you will not be able to participate in this research study. Agreeing to this the form is not a condition for receiving any medical care outside the study.

4. If I agree, can I revoke it or withdraw from the research later?

If you decide to participate, you are free to withdraw your authorization regarding the use and disclosure of your health information (and to discontinue any other participation in the study)

at any time. After any revocation, your health information will no longer be used or disclosed in the study, except to the extent that the law allows us to continue using your information (e.g., necessary to maintain integrity of research). If you wish to revoke your authorization for the research use or disclosure of your health information in this study, you must write to:

Drs. Derek Amanatullah, Nicholas Giori, Stuart B. Goodman, James Huddleston, William Maloney, Matthew Miller, Steven Woolson
Department of Orthopaedic Surgery
450 Broadway Street, M/C 6342
Redwood City, CA 94063

5. What Personal Information Will Be Used or Disclosed?

Your health information related to this study, may be used or disclosed in connection with this research study, including, but not limited to, basic patient demographics, including Patient name, , address, phone number, email address, date of birth, and insurance information, self-administered questionnaires, surgical data, related physical examination records, and x-rays.

6. Who May Use or Disclose the Information?

The following parties are authorized to use and/or disclose your health information in connection with this research study:

· The Protocol Director: *Stuart Goodman, MD, PhD*

· The Co-Investigators: *Derek Amanatullah, MD*
Nicholas Giori, MD
James Huddleston, MD,
William Maloney, MD
Matthew Miller, MD
Steven Woolson, MD

· The Research team: *Angela Bye,*
Katherine Hwang
Stanford Orthopaedic Fellows

· The Stanford University Administrative Panel on Human Subjects in Medical Research and any other unit of Stanford University as necessary.

7. Who May Receive / Use the Information?

The parties listed in the preceding paragraph may disclose your health information to the following persons and organizations for their use in connection with this research study:

· The Office for Human Research Protections in the U.S. Department of Health and Human Services

Your information may be re-disclosed by the recipients described above, if they are not required by law to protect the privacy of the information.

8. When will my authorization expire?

Your authorization for the use and/or disclosure of your health information will expire December 31, 2075.

Patient MRN Label