**VCU Medical Center**

# Authorization for Use and Disclosure Of

# Patient Health Information in Research

**IRB Study #:**

**Study Title:**

## Principal Investigator:

*[Include if appropriate]* In this authorization form, “you” always refers to the research participant. If you are a legally authorized representative, please remember that “you” refers to the study participant.

You have been given a consent form that tells you about this Research Study and any activities or procedures that are part of the study. This form tells you what health information about you may be used and given out in the study and who may give and receive the information. **By signing this form, you agree that the health information that identifies you may be used and disclosed as needed for this research.** The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides for the protection of your health information from unauthorized use or disclosure.

**Authority to Request Protected Health Information**

The following people and/or groups may request my Protected Health Information:

|  |  |
| --- | --- |
| * Principal Investigator and Research Staff | * Study Sponsor |
| * Research Collaborators | * Institutional Review Boards |
| * Data Safety Monitoring Boards | * Government/Health Agencies |
| * Others as Required by Law |  |

### Authority to Release Protected Health Information

The VCU Medical Center (VCUMC) may release the information identified in this authorization from my medical records and provide this information to:

|  |  |
| --- | --- |
| * Health Care Providers at the VCUMC | * Principal Investigator and Research Staff |
| * Study Sponsor | * Research Collaborators |
| * Data Coordinators | * Institutional Review Boards |
| * Data Safety Monitoring Boards | * Government/Health Agencies |
| * Others as Required by Law |  |

Once your health information has been disclosed to anyone outside of this study, the information may no longer be protected under this authorization.

**Type of Information that may be Released** [This section to be filled-out by the Principal Investigator. Double click on the check boxes to insert check]

The following types of information may be used for the conduct of this research:

|  |  |  |  |
| --- | --- | --- | --- |
| Complete health record | Diagnosis & treatment codes | | Discharge summary |
| History and physical exam | Consultation reports | | Progress notes |
| Laboratory test results | X-ray reports | | X-ray films / images |
| Photographs, videotapes | Complete billing record | | Itemized bill |
| Information about drug or alcohol abuse | | Information about Hepatitis B or C tests | |
| Information about psychiatric care | | Information about sexually transmitted diseases | |
| Other (specify): | | | |

#### Uses of Your Protected Health Information [This section to be filled out by the Principal Investigator]

The purpose of this research study is       [Provide a brief description of the research study]

Your health information as shown above will be used for the following reasons:

|  |
| --- |
| To determine if you meet the requirements to be a participant in this study |
| To be able to conduct the study |
| For safety monitoring |
| For regulatory issues |
| Other (specify): |

**Expiration of This Authorization [**This section to be filled out by the Principal Investigator]

|  |
| --- |
| This authorization will expire when the research study is closed, or there is no need to review, analyze and consider the data generated by the research project, whichever is later. |
| This research study involves the use of a Data or Tissue Repository (bank) and will never expire. |
| Other (specify): |

### Right to Revoke Authorization and Re-disclosure

You may change your mind and revoke (take back) this Authorization at any time. Even if you revoke this Authorization, the researchers may still use or disclose health information they have already collected about you for this study. If you revoke this Authorization you may no longer be allowed to participate in the research study. To revoke this Authorization, you must write to the Principal Investigator named above or in the Informed Consent document.

## Signature of Research Participant or Personal Representative

I understand that I do not have to sign this authorization. If I decide not so sign, I understand:

* It will not affect my treatment, payment or enrollment in any health plans or affect my eligibility for benefits.
* I may not be allowed to participate in the research study, and may not have access to research-related therapy / treatment.
* I can inspect, and in some cases copy, the Protected Health Information to be used or disclosed.

**Participant Signature Date**

**Printed Name**

**[REMOVE LAR SECTION IF NOT APPLICABLE]**

**Legally Authorized Representative Signature Date**

**Description of relationship**

**Description of Authority to Sign for the Research Participant**

**A COPY OF THIS AUTHORIZATION IS TO BE GIVEN TO THE PERSON SIGNING**