**VERBAL HIPAA AUTHORIZATION TEMPLATE**

**[In seeking HIPAA authorization, certain elements and statements are required by regulation to be provided to subjects in order to obtain valid authorization. This template contains all of the required elements except for the participant’s signature.**

**In order to use this template for expedited and full board studies, you must request a Partial Waiver of the following two items: 1) the authorization signature and 2) the requirement to provide the subject with a copy of the signed authorization.**

**In addition, if you choose not to include all of the required elements in your script, you must request a Partial Waiver of some elements of authorization and list the elements that you want to waive. For more information, see WPP XII-3 (**[**http://www.research.vcu.edu/human\_research/irb\_wpp/XII-3.htm**](http://www.research.vcu.edu/human_research/irb_wpp/XII-3.htm)**)]**

[Instructions and comments are in italics and []. Please modify this template as applicable to your study, delete all instructions and comments, and remove all yellow highlighting when finished reading and editing.]

Your privacy is important to us. As part of our research study about *[state the purpose of the research]*, we will ask you to share identifiable health information with us. This type of information is considered “Protected Health Information” that is protected by federal law.

You have the right to decide if you want to give your permission before your health information can be used or shared for certain purposes. We are asking you to authorize the use and release of specific Protected Health Information as part of our research.

To conduct this research study, we are asking for permission to use or release your *[describe the type of PHI to be used or disclosed, including all that apply:* 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*, or specify others as applicable]*.

The following people or groups may request to use your health information: *[include all that apply:* the Researchers and their Staff, Research Collaborators, Data Safety and Monitoring Boards, the Study Sponsor, Data Coordinators, Institutional Review Boards, Government/Health Agencies, Others as Required by Law*]*.

By agreeing to this authorization, you give permission to VCUHS and the Principal Investigator to release health information from your medical and/or research records and give it to: *[include all that apply:* the Researchers and their Staff, Health Care Providers at VCUHS, Research Collaborators, Data Safety and Monitoring Boards, the Study Sponsor, Institutional Review Boards, Government/Health Agencies, Others as Required by Law*].*

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

*[EXPIRATION OF AUTHORIZATION – Choose Option 1, 2, or 3 as appropriate]*

*[Option 1]* This Authorization will expire when the research study is closed, or there is no need to review, analyze, and consider the data created by the research project, whichever is later.

*[Option 2]* This research study involves the use of a Data or Tissue Bank, so this Authorization will never expire.

*[Option 3]* This Authorization will expire when *[specify any other expiration date or event not covered by Option 1 or 2]*.

You may change your mind and take back the right to use your protected health information at any time. However, even if you take back your Authorization, the researchers may still use or release any health information that they have already collected about you for the study. If you take back this Authorization, you may no longer be allowed to participate in the research study. To take back this Authorization, you must write to *[insert the Principal Investigator’s name and mailing address]*.

Do you have any questions about how your health information will be used and released in this study?

*[AUTHORIZATION STATEMENT – Choose either Option 1 OR 2 as appropriate]*

*[Option 1: If authorization is given by the research participant:]*

Do you agree that health information that identifies you may be used and disclosed for this research as we previously described?

\_\_\_\_\_\_\_\_ YES

\_\_\_\_\_\_\_\_ NO

*[Option 2: If authorization is given by the research participant’s personal representative:]*

Do you agree that health information that identifies [use the research participant or individual’s name] may be used and disclosed for this research as we previously described?

\_\_\_\_\_\_\_\_ YES

\_\_\_\_\_\_\_\_ NO

Please describe your authority to act for the participant.

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