**Authorization to Use or Share Health Information   
that Identifies You for a Research Study**

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| **\*\*Delete this instructional table after filling out the template\*\***   * Instructional text and/or guidance is designated in *blue italic font*. Please delete this box and the blue, italicized instructional text before submitting for review. * Contact the Office of Research Integrity at [irb@une.edu](mailto:irb@une.edu) if you have questions or need further assistance. |

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| Version Date: | *[This is the date the authorization form was initially created or subsequently revised]* |
| IRB Study #: | *[An IRB Study # will be assigned to you upon receipt of your submission]* |
| Title of Study: |  |
| Study Sponsor: | *[Delete this row if there is no study Sponsor]* |
| Principal Investigator (PI): | *[There can only be one individual listed as the PI of the study]* |
| PI Contact Information: | *[Provide the UNE e-mail address and phone number of the PI]* |

**WHAT IS THE PURPOSE OF THIS FORM?**

You have been asked to take part in a research study. The consent form for this study describes your participation, and that information still applies. This extra form is required by the federal Health Insurance Portability and Accountability Act (HIPAA). This form relays what health information about you may be collected in this research study and who might see or use it.

**WHAT INFORMATION MAY BE USED OR SHARED?**

In order to conduct this research study, we will need to use or share your health information. By signing this form, you are allowing:

* Your health care providers to share your health information for this research study.
* The research team to use and share your health information for this research study.

Health information about you that will be used or shared with others involved in this research study may include your research record and any health care records at *[name of covered entity]*. Specifically, this will include the following:

* [Using a bulleted list, describe the **health information and the HIPAA identifiers** to be used or shared for the study. This may include, for example, identifiers (e.g., name, medical record number, date of birth), results of physical examination, medical history, lab tests, radiology images, specimen photos, operative reports, pathology reports, physician notes, or certain health information indicating or relating to a particular condition.]

**WHO WILL SEE, USE, OR SHARE THE INFORMATION?**

The people who may request, receive, or use your health information include the researchers and their staff. Additionally, we may share your information with other people at *[name of covered entity]*, for example if needed for your clinical care or study oversight. If this study is related to your medical care, your research-related information may be placed in your electronic medical record.

By signing this form, you also give permission to the research team to share your health information with others outside of *[name of covered entity]*. Examples include government agencies, safety monitors, other sites in the study, and companies that sponsor the study.

We try to make sure that everyone who sees your health information keeps it confidential, but we cannot guarantee your information will not be shared with others. If your health information is disclosed by your health care providers or the research team to others, federal and state confidentiality laws may no longer protect it.

**DO YOU HAVE TO SIGN THIS FORM?**

You do not have to sign this form. If you do not sign this form, you cannot take part in this research study.

**HOW LONG WILL YOUR INFORMATION BE USED OR SHARED?**

Your authorization for the use and sharing of your health information does not expire.

**WHAT IF YOU CHANGE YOUR MIND?**

You can change your mind and withdraw this permission at any time by sending a written notice to the Principal Investigator at the contact information listed at the top of this form to inform the researcher of your decision. If you withdraw this permission, the researcher may only use and share your information that has already been collected for this study. No additional health information about you will be collected by or given to the research team for the purpose of this study.

**MAY YOU REVIEW OR COPY THE INFORMATION OBTAINED OR CREATED ABOUT YOU?**

Yes, you have the right to review and copy your health information. However, your access to this information may be delayed until the study is complete.

Your decision to withdraw your authorization or not to participate will not involve any penalty or loss of access to treatment or other benefits to which you are entitled.

**AUTHORIZATION**

I am the research participant or the personal representative authorized to act on behalf of the participant. By signing this form, I am giving permission for my identifiable health information to be used in research as described above. I will be given a copy of this authorization form after I have signed it.

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| Signature of patient or patient’s personal representative |  | Date |

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| Printed name of patient or patient’s personal representative *(e.g., patient is a minor, incapacitated, deceased)* |  | If applicable, a description of the personal representative’s authority to sign for the patient |

#### Researcher Signature:

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| Signature of research team member |  | Date |

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| Printed name of research team member |