TEMPLATE PROVIDED BY ECHN (enter your name/institution here)
Authorization (Permission) to Use or Disclose (Release) Identifiable Health Information for Research

Participant's Name: _____

Birth Date: _____

1. What is the purpose of this form?

Researchers would like to use your health information for research. This information may include data that identifies you. Please carefully review the information below. If you agree that researchers can use your personal health information, you must sign and date this form to give them your permission.

2. What personal health information do the researchers want to use?

The researchers want to copy and use the portions of your medical record that they will need for their research. If you enter a research study, information that will be used may include the following:

You may request a blank copy of the data forms from the study doctor or his/her research staff to learn what information will be shared.

3. Why do the researchers want my personal health information?

_____PI, MD/PhD/etc. will collect your health information for this research study. You are being asked to take part in a study known as
"_____

_____

_____"

4. Who will be able to use my personal health information?

_____PI, MD/PhD/etc. will use your health information for research. As part of this research, they may disclose your information to the following groups taking part in the research. The medical information that is disclosed will not identify you personally (for example, by name, address or social security number). Instead the study staff will assign a code number and/or letters to the data so that you will not be identified. However, _____PI,MD/PhD/etc. may also permit the following groups to come in to review your original records, that would identify you, that are kept by _____PI,MD/PhD/etc. so that they can monitor their research study**:**

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- ECHN Institutional Review Committee
- Public Health agencies and other government agencies (including non-U.S.) as authorized or required by law;

5. How will information about me be kept private?

_____PI,MD/PhD/etc. will keep all patient information confidential and will only release this information to the groups listed above.

However, once the Medical Personnel have disclosed your PHI to third parties that are not required to follow Federal Privacy laws, the Medical Personnel can not assure that the PHI will remain protected or will not be redisclosed.

6. What happens if I do not sign this permission form?

If you do not sign this permission form, you will not be able to take part in the research study for which you are being considered. You have a right to refuse to sign this authorization. Your health care outside the study, the payment for your health care, and your health care benefits will not be affected if you do not sign this form, but you will not be able to enroll in the research study described in this authorization and will not receive treatment as a study participant if you do not sign this form.

7. If I sign this form, will I automatically be entered into the research study?

No, you cannot be entered into any research study without further discussion and separate consent. After discussion, you may decide to take part in the research study. At that time, you will be asked to sign a specific research consent form.

8. What happens if I want to withdraw my permission?

You can change your mind at any time and withdraw your permission to allow your personal health information to be used in the research. If this happens, you must withdraw your permission in writing. Beginning on the date you withdraw your permission, no new personal health information will be used for research. However, researchers may continue to use the health information that was provided before you withdrew your permission.

If you sign this form and enter the research study, but later change your mind and withdraw your permission, you will be removed from the research study at that time.

To withdraw your permission, please contact the person below. He/she will make sure your written request to withdraw your permission is processed correctly.

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9. How long will this permission last?

If you agree by signing this form that researchers can use your personal health information, this permission has no expiration date. However, as stated above, you can change your mind and withdraw your permission at any time.

10. What are my rights regarding access to my personal health information?

You have the right to refuse to sign this permission form. You have the right to review and/or copy records of your personal health information kept by _____PI, MD/PhD/etc.

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Signatures

I agree that my personal health information may be used and/or disclosed for the research purposes described in this form. I understand that I will receive a signed copy of this authorization form.

Printed Name of Subject_____

Signature of Subject_____Date: _____

Printed Name of Legal Representative (if applicable): _____

Representative's Authority to Act for Subject:
____Parent/Guardian ____Administrator/Executor of Estate ____Power of Attorney ____Other-specify

Signature of Legal Representative: _____ Date: _____

Printed Name of Person Obtaining Authorization: _____

Signature of Person Obtained Authorization:_____Date: _____

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