AUBURN UNIVERSITY (AU)
AUTHORIZATION FOR USE/DISCLOSURE OF
PROTECTED HEALTH INFORMATION (PHI) FOR RESEARCH

Participant Name: _____ **AU IRB Protocol Number:** _____

Sponsor: _____ **Principal Investigator:** _____

Protocol Title: _____

_____

What is the purpose of this form? You are being asked to sign this form so AU may use and release your protected health information for research. Participation in research is voluntary. If you choose to participate in the research, you must sign this form so that your protected health information may be used for the research.

Why do the researchers want my protected health information? The researchers want to use your protected health information as part of the research protocol listed above and as described to you in the informed consent.

What protected health information may be used and/or given to others: Federal regulations give you certain rights related to your health information. These include the right to know who will be able to receive your PHI and why they may receive. The Principal Investigator must have your authorization (permission) to use or share any health information that might identify you. For this research we are requesting all medical information, including but not limited to information and/or records of any diagnosis or treatment of disease or condition, which may include sexually transmitted diseases (e.g., HIV, etc.) or communicable diseases, drug/alcohol dependency, etc.; all personal identifiers, including but not limited to your name, social security number, medical record number, date or birth, dates of service, etc.: any part, present, and future history, examinations, laboratory results, imaging studies and reports and treatments of whatever kind, including but not limited to drug/alcohol treatment, psychiatric/psychological treatment; financial/billing information, including but not limited to copies of your medical bills, and any other information related to or collected for use in the research protocol, regardless of whether the information was collected for research or non-research (e.g., treatment) purposes.

Who will disclose, use and/or receive my protected health information? All individuals/entities listed in the informed consent documents, including but not limited to, the Principal Investigator, approved staff and others performing services related to the research (whether at AU or elsewhere); other operating units of AU, as necessary for their operations; the Institutional Review Board (IRB) and its staff; the sponsor of the research and its employees and agents, including any Contract Research Organization (CRO). In addition, outside regulatory agencies may use and/or receive your PHI. The outside regulatory agencies include the Office of Human Research Protections (OHRP), the Department of Health and Human Services (DHHS) and the Food and Drug Administration, each of whom provide oversight or perform other legal and/or regulatory functions for which access to participant information is required.

How will my protected health information be protected once it is given to others? Your protected health information that is given to the study sponsor will remain private to the extent possible, even though the study sponsor is not required to follow the federal privacy laws. However, once your information is given to other organizations that are not required to follow federal privacy laws, we cannot assure that the information will remain protected.

How long will this Authorization last? Your authorization for the uses and disclosures described in this Authorization does not have an expiration date.

Can I cancel this Authorization? You may cancel this Authorization at any time by notifying the Principal Investigator, in writing, referring to the research protocol and AU IRB Protocol Number. If you cancel this Authorization, the Principal Investigator and approved staff will not use any new health information for research. However, researchers may continue to use the protected health information that was provided before you cancelled your authorization.

Can I see my protected health information? You have a right to request to see your protected health information. However, to ensure the scientific integrity of the research, you will not be able to review the research information until after the research protocol has been completed.

Signature of the participant: _____ Date: _____

Or participant's legally authorized representative: _____ Date: _____

Printed Name of participant's representative: _____

Relationship to the participant: _____

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Authorization/Release of Designated Medical Records: The Department of Health and Human Services (DHHS), under the collective body laws, and amendments, known as HIPAA, (The Health Information Portability and Accountability Act), requires a separate authorization/release for certain medical records. This release is in addition to the authorization signed on Page 1. These medical records include the diagnosis and/or treatment for:

1. HIV/Aids
2. Psychotherapy notes
3. Substance Abuse Disorder
4. Genetic Information

In the event your medical records include the diagnosis and/or treatment for either of the above medical conditions, please confirm below by selecting the appropriate box, initialing by the checked box AND signing and dating the authorization below:

☐ HIV/Aids Initial: _____

☐ Psychotherapy Notes Initial: _____

☐ Substance Abuse Disorder Initial: _____

☐ Genetic Information Initial: _____

Signature of the participant: _____ Date: _____

Or participant's legally authorized representative: _____ Date: _____

Printed Name of participant's representative: _____

Relationship to the participant: _____

Witness: _____ Date: _____