**Authorization for Disclosure of Protected Health Information for Research**

**[TITLE OF THE STUDY]**

**Instructions:** Standard language appears in black font and should be included in your form; however, it may need to be modified to fit your study. Replace directions/guidance [in red font] with the appropriate information. Be consistent with the IRB submission. Remove all text in red font in the final form. Keep the margin size.

We are asking you to authorize the disclosure (release) and use of your private health information for this research study. *Private health information* means the health information in your medical or other healthcare records that can identify you. Specifically, this information will be used to [determine whether you meet the conditions for participation in this study; to compare your earlier test results to the findings from this study; to use your previous laboratory results in place of, or in addition to, some of the lab results needed for this study].

By signing this Authorization, you permit the following Health Care Provider/s to release your private health information to us for use in this research study. You do not have to sign this form. If you do not, you [insert the appropriate words: will not OR will still] be able to join the research study. Your decision to not sign this permission will not affect the current and/or future treatment, health care services, or eligibility for benefits you receive from [the name of doctor’s clinic, pharmacy, or health facility].

Name of Health Care Provider: [List Provider/s]

Your private health information that we may use for this research includes: [Your diagnosis, past medical history, diagnostic procedures, and results of any tissue biopsies or blood tests, including results of genetic tests that were already done as part of your standard treatment.]

The health information listed above may be used by and/or disclosed to: [Name or class of persons involved in the research; i.e., researchers and their staff]

The researchers will protect your privacy and the confidentiality of your records by using the same procedures described in the consent document. However, we cannot guarantee the confidentiality of your medical information once this is disclosed to others outside of the research team. Some other people may see your information outside of the research team.  They may include the University’s Institutional Review Board and other regulatory offices [add, if applicable: sponsor of the study; study safety monitors].   All these people must also protect your information.

As part of this research study, some information that we obtain from you will be placed into your medical records held at [name of doctor’s clinic, pharmacy, or health facility].

This Authorization expires at the end of the research study [or revise accordingly]. You have a right to request to see your 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 [or revise accordingly].

You may change your mind and take back this Authorization at any time.  If you take it back, the researchers may still use the private health information they have obtained about you as necessary to maintain the integrity or reliability of the current research. [If you revoke this Authorization, you may no longer be allowed to participate in the research described in this Authorization.] To take back the Authorization, you must write to the following researcher:

[Name and contact information – address, email, phone number]

Please read the information carefully before signing this form. Please ask any questions about this authorization or the study before signing this form.

**Signature** By signing below, I authorize the use and disclosure of my personal health information as described above for this study.

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Name of Researcher Signature Date

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Name of Participant Signature Date

Please sign both copies, keep one and return one to the researcher.