AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION FOR RESEARCH PURPOSES

The federal privacy law, Health Insurance Portability & Accountability Act (HIPAA), protects your individually identifiable health information from being shared without your permission. The privacy law requires that you sign an authorization (or agreement) in order for researchers to be able to use and disclose your protected health information and that you receive a copy of the Institution's privacy practices.

Your signature on this authorization is voluntary. Whether you choose to sign or not to sign has no impact on your treatment, payment, or enrollment in any health plans, or affect on your eligibility for benefits. The only consequence of not signing this form is that you may not be allowed to participate in this research project.

By signing this form you authorize ***[name of researcher(s)]*** and ***[his, her, their]*** staff to use and disclose your protected health information for the research project titled ***[Insert title of study***], described in more detail later in this form. You also permit your doctors and other health care providers to disclose your protected health information for this research project.

In addition, State of Connecticut statutes require that any release of information pertaining to AIDS, HIV infection, behavioral health services, psychiatric care, or treatment for alcohol and/or drug abuse be specifically authorized. **If** this information pertains to you, you should know that the researcher(s) and staff associated with this project might become aware of it. By signing this dual-purpose authorization you acknowledge that you understand there is a chance this information may be subject to use and disclosure as it relates to this project.

This Authorization does not have an expiration date. However, if you sign this authorization you can still **change your mind** at a later date. You can revoke this authorization by sending a written notice to ***[name and address]*** to inform ***[him, her]*** of your decision. Once you revoke this authorization the researchers will no longer be able to use and disclose your protected health information. There are exceptions to this. For example, one exception under which the researchers may continue to use and or disclose your protected health information after receiving your request to revoke the authorization is if you experience(d) an adverse event (bad effect). Another example is that researchers may continue to use and /or disclose only the protected health information collected for the research study prior to receiving the request to revoke this authorization. If you revoke this authorization you may no longer be allowed to participate in this study.

If you have any **questions, concerns or complaints** about your privacy rights, you may write to the Director of Patient Relations at the University of Connecticut Health Center, 263 Farmington Avenue, Farmington CT 06030-1112. If you have a complaint, you may also write to the Federal Department of Health and Human Services (DHHS) at DHHS Regional Manager, Office of Civil Rights, U.S. Dept. of Health and Human Services Government Center, J.F. Kennedy Federal Building, Room 1875, Boston MA 02203. Complaints should be sent within 180 days of when you knew, or should have known, of the problem.

You may not be allowed to review the information collected for this research project until ***[choose one or both: the collection of information is complete and/or the study is complete.]*** However, you have the right to request that your medical record be released to your personal physician. When ***[choose one or both: the collection of information is complete and/or the study is complete]***, you may have the right to access all of your information.

Your protected health information that may be used and disclosed includes:

- [List all of the specific Protected Health Information[1] to be collected for this protocol/study such as demographic information, results of physical exams, blood tests, X-rays, and other diagnostic and medical procedures as well as medical history].

Your Health Information will be used for:

- [Provide the title and brief description of the research project. You can paste information from the purpose section in the Informed Consent Form.]

Your Protected Health Information may be used by and shared with:

- The University of Connecticut Health Center's Institutional Review Board and the Office of Research Compliance.
- Government representatives, when required by law.
- Hospital or University of Connecticut Health Center representatives.
- [List any collaborators, outside laboratories, etc].
- [If applicable, list the sponsor's name].
- [List any other group with whom the information may be shared].
- [If information will be placed in a medical record as opposed to a research record, indicate that information placed in the medical record may be available to the subject's insurer or to government agencies as required by law.]
- [If a Certificate of Confidentiality applies to this study this section may be modified accordingly and the protections afforded by the Certificate should be described.]

The researchers and staff agree to protect your health information by using and disclosing it only as permitted by you in this Authorization and as directed by state and federal law. However, once your health information has been disclosed to anyone outside of this institution, the information may no longer be protected under this authorization.

Reasons to share the information are to be able to conduct research, and to ensure that the research meets legal, institutional and/or accreditation requirements.

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[1] Individually identifiable information includes name, address, dates directly related to an individual, telephone/fax numbers, e-mail/internet protocol or web url address, social security number, medical record or health plan number, account number, certificate or license number, photographic images, vehicle identifiers, device identifiers, biometric identifiers (for example, finger prints), any other unique identifier. **Protected health information** includes all individual identifiers and information that relates to the past, present or future physical or mental health conditions of an individual.

Medical research may result in new products, tests or discoveries. These may have commercial value and may be developed and owned by the University of Connecticut Health Center, its faculty and/or others. Please initial to acknowledge that you understand that you will not share in the financial benefits, if any, from these products tests or discoveries.

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The University of Connecticut Health Center's Notice of Privacy Practice is provided to all patients and research participants. The Notice is also available on-line at http://health.uchc.edu/privacy/index.htm. The Notice explains how your medical information may be used and disclosed and how you can get access to this information.

Please initial the appropriate choice:

______You have already received the University of Connecticut Health Center's Notice of Privacy Practice and understand your rights and the policy of the institution.

______You have been provided with a hard copy of the University of Connecticut Health Center's Notice of Privacy Practice by the researcher(s) and have been given the opportunity to read it and ask questions prior to signing this form.

There may be studies conducted in the future for which you may be an eligible participant. Please initial your preference.

______You **give** permission to ***[insert researcher(s) name]*** or ***[his, her, their]*** designated database administrator to contact you with information about future studies for which you may be an eligible participant.

______You **do not give** permission to be contacted about future studies for which you may be an eligible participant.

You are a voluntary participant in this research study, or you are authorized to act on behalf of the participant. By signing you acknowledge that you have read and understand this form and that you authorize the use and disclosure of protected health information. You will receive a copy of this form after it is signed.

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Signature of the research participant or the research participant's legal representative*. Date

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Printed name of the research participant **and** if applicable the participant's legal representative*

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Representative's relationship to the research subject

*Please provide documentation of your status as a health care representative