Sample Document

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR RESEARCH

The University of Rhode Island

Department of \_\_\_\_\_\_\_\_\_\_\_\_\_\_

[Address]

[Title of Project]

The privacy law, Health Insurance Portability & Accountability Act (HIPAA) protects individually identifiable health information. The privacy law requires that an investigator explain in detail what information will be obtained during a study and how that information will be used, and with whom it will be shared.

You have been asked to participate in the above named study. The protected health information that may be used and disclosed includes:

(*State all health information needed for the study)*

The investigators may use and disclose your protected health information until the end of the study *(please provide end date or expiration of authorization*.) They will use and/or share this information with:

The University of Rhode Island Institutional Review Board

Government Agencies when required by law

(*List all other agencies or individuals with whom information will be shared)*

You do not have to sign this authorization. If you do sign, you may end your participation by notifying the investigator (*name and telephone # of investigator).* Withdrawal of authorization will not affect treatment, payment or enrollment in any health plans or affect your eligibility for benefits. When you withdraw authorization investigators may only use and disclose the protected health information already collected for this research study. Withdrawal of authorization also means that you may not be allowed to participate in the study.

The investigator will respect the confidentiality of the health information, however, should the health information be disclosed by the investigator, to someone outside of this study, it may no longer be protected by the HIPAA regulation.

Signing your name at the bottom of this form means that you have read or listened to what it says and you understand it. Signing this form also means that you agree to authorize the use and disclosure of personal health information. You will be given a copy of this form after you have signed it.

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Signature of participant Signature of Researcher

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Date Date