Authorization Form For the Use and Disclosure of Patient Health Information for Research Purposes

Name of Research Study: _____

Name of Principal Investigator(s): _____

Principal Investigator(s) Contact information: _____

_____

Researchers at the University of Wisconsin – Milwaukee (UWM) are required to obtain written permission to use and/or disclosure your Protected Health Information in connection with a research study. This permission is called an "Authorization." In order to take part in the research study described below you must sign this Authorization Form.

How will my information be used?

Your health information will be used in a research study about **[insert description of study.]**

What type of information will be used and/or disclosed?

The type of information that will be used, collected and/or disclosed is as follows:

[Modify as appropriate]

- ❑ Information in your medical records (from _____ to _____)
- ❑ Your medical records from the hospitals and clinics where you receive care
- ❑ Your medical records related to the evaluation and treatment of [insert name of medical condition] and other significant medical conditions]
- ❑ HIV/AIDS Status
- ❑ Lab Results
- ❑ Alcohol and Drug Treatment*
- ❑ Mental Health/Psychiatric Care*
- ❑ All of your medical records
- ❑ Information/data about your health obtained from the research activities of this study. This data/information will include [insert details]
- ❑ Information/data about your health obtained from laboratory testing during the course of this study. This data/information will include [insert details]
- ❑ Information/data collected during the researcher's observation of you. This data/information will include [insert details]
- ❑ Other: _____]

[*Note that you must obtain a separate authorization form for disclosure of psychotherapy notes that may comprise portions of these records.**]**

Who will be receiving, using or disclosing this information?

By agreeing to participate in this research study, you are giving permission to the following individuals (collectively, the "Research Team") to receive, use and disclose your health information for activities relating to this research study:

- Principal Investigators as well as their researchers and staff, and other UWM administrative personnel and research support services.

- Researchers, staff and other administrative personnel and research support services of **[insert names of other hospitals/entitles collaborating on the study, if any].**

Further, you are giving permission to **[insert name(s) of holders of information sought]** to share the information needed for this study with the Research Team. **[Note:** Common medical record holders include hospitals, rehabilitation and nursing facilities, primary care providers, schools, clinics and dentists**]**.

How long does my consent last and can I revoke it?

Unless you decide to stop participating earlier, your consent to use the information obtained in this study **[**will expire at the end of the study**] [**has no expiration date**]**. You have the right to revoke your consent at any time, however, by withdrawing your permission in writing. Beginning on the date your permission ends, no new health information will be used. Any new health information that was shared before you withdrew your permission will continue to be used. After you withdraw your consent, you can no longer actively take part in this study.

Withdrawal of your permission should be made in writing to the person whose name is listed here:

[Insert Principal Investigator's name and address**.]**

Do I have to participate in the research study and sign this consent?

Taking part in this study is voluntary. You do not have to sign this consent form and you may refuse to do so. Your health care providers cannot deny you health care services because you refuse to sign this consent form. If you refuse to sign this form, however, you cannot take part in this research study.

Can I obtain a copy of the information used and/or disclosed pursuant to this consent?

By signing below, you are agreeing that access to any of your protected health information that is used for this research study may be suspended during the study, but your access will be reinstated upon completion of the study.

Will my health information remain confidential?

Every effort will be made to maintain your confidentiality. **[Note:** You may want to insert information here about the de-identification of personal information for publication purposes and where information will be kept (locked filing cabinet, etc.) per the IRB rules**].**

The University of Wisconsin – Milwaukee **[**and [inset names of other research partners/entities, if applicable]**]** have rules to protect your personal information. Other state and federal rules also protect your rights as a research participant. We will use and disclose your information only as described in this form, however, information used or disclosed pursuant to this consent may no

longer be protected under the Federal law that protects health information, and therefore could be subject to redisclosure.

Can I think about this?

You should take as much time as you need to make your decision about giving permission for the use of your health information for this research study. Please ask any questions you have about this research study and this consent form.

<u>Permission to use and/or disclose my health information</u>:

I have read this Authorization form describing how my health information will be used and/or disclosed. I have had a chance to ask questions about the use and disclosure of my health information and I have received answers to my questions. By signing below, I authorize the receipt, use and/or disclosure of my health information described above in connection with this research study.

_____ _____
Signature of patient or parent or legal guardian Date

_____
Printed name of patient

_____
Printed name of parent or legal guardian (if applicable)

_____
Relationship to patient (if applicable)

**** You should receive a copy of this Authorization after signing it.****