Note (delete this note before submitting to OIRB):

Blue text in brackets is information that needs to be entered.

Red text is optional, sample phrasing.

Do NOT delete the bold black heading questions.

Title of Project

Authorization to Access Protected Health Information for Research Purposes

|  |  |
| --- | --- |
| PRINCIPAL INVESTIGATOR: |  |
| CONTACT INFORMATION: | [Mailing address, Phone number, Fax number, email address, etc.] |
| FUNDING AGENCY: | [National Institutes of Health, Name of Pharmaceutical Company, etc.] |

**What is the purpose of this form?**

You have been asked to take part in a research study. The consent form for this study describes your participation, and that information still applies. This extra form is required by the federal Health Insurance Portability and Accountability Act (HIPAA)1. The purpose of this form is to get your permission (authorization) to use protected health information about you that is created by or used in connection with this research.

**What if I don’t want my personal health information (PHI) to be used in this research study?**

You do not have to give this permission. Your decision not to sign this form will not change your ability to get health care outside of this research study. However, if you do not sign, then you will not be allowed to participate in the study.

**What PHI am I allowing to be used for this research?**

The information that may be used includes: (READ AND DELETE THESE INSTRUCTIONS. HIPAA requires a “specific and meaningful description” of the information. This should be as specific as possible but should also be broad enough to cover ALL information that may be needed during this study and frequency of access. Examples may include: “…supporting information from your entire medical record, results of lab tests, information from follow-up visits…”)

**Where will researchers go to find my PHI?**

We may ask to see your personal information in records at hospitals, clinics or doctor’s offices where you may have received care in the past, including but not limited to facilities in the UNM health care system.

**Who will be allowed to use my information for this research and why?**

The researchers that will be allowed to see and use your health information for this research study include: [List people accessing PHI or if providing separate list of people, state "will be provided to you"]. It may be used to check on your progress during the study, or analyze it along with information from other study participants. Sometimes research information is shared with collaborators or other institutions. Your records may also be reviewed by: people from the research sponsor/funding agency or federal regulatory agencies to check for quality, safety or effectiveness; or the IRB for the purposes of oversight and subject safety and compliance with human research regulations.

**Will my information be used in any other way?**

In addition to researchers and staff at UNM and other groups listed in this form, there is a chance that your health information may be shared (re-disclosed) outside of the research study and no longer be protected by federal privacy laws. Examples of this include disclosures for law enforcement, judicial proceeding, health oversight activities and public health measures.

**What if I change my mind after I give this permission?**

You can change your mind and withdraw this permission at any time by sending a written notice to the Principal Investigator at the contact information listed at the top of this form to inform the researcher of your decision. If you withdraw this permission, the researcher may only use and share your information that has already been collected for this study. No additional health information about you will be collected by or given to the researcher for the purposes of this study.

**What are the privacy protections for my PHI used in this research study?**

HIPAA regulations apply to personal health information in the records of health care providers and other groups that share such information. There are some differences in how these regulations apply to research, as opposed to regular health care. One difference is that you may not be able to look at your own records that relate to this research study. The HIPAA privacy protections may no longer apply once your PHI has been shared with others who may be involved in this research.

**How long does this permission allow my PHI to be used?**

If you decide to be in this research study, your permission to access and use your health information in this study may not expire, unless you revoke or cancel it. Otherwise, we will use your information as long as it is needed for the duration of the study.

If you have questions about the privacy practices of the entity from which your PHI is being collected, you can request a Notice of Privacy Practices from your provider.

**AUTHORIZATION**

I am the research participant or the personal representative authorized to act on behalf of the participant. By signing this form, I am giving permission for my protected health information to be used in research as described above. I will be given a copy of this authorization form after I have signed it.

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Name of Research Participant Signature of Participant Date

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Name of Researcher Signature of Researcher Date