

HIPAA AUTHORIZATION FORM

Authorization for the Use and Disclosure of Personal Health Information Resulting from Participation in a Research Study

FOR IRB USE ONLY	
APPROVED	

_____ IRB Authorized Representative	_____ Date

Principal Investigator's Name:
Project #
Project Title:

You have agreed to participate in the study mentioned above. This authorization form gives more detailed information about how your health information will be protected.

1. Description of the information

My authorization applies to the information described below. Only this information may be used and/or disclosed in accordance with this authorization:

2. Who may use and/or disclose the information

I authorize the following persons (or class of persons) to make the authorized use and disclosure of my PHI:

3. Who may receive the information

I authorize the following persons (or class of persons) to receive my personal health information

4. Purpose of the use or disclosure

My PHI will be used and/or disclosed upon request for the following purposes:

Publications and presentation that will not identify me, auditing, administrative and billing reviews, study outcomes including safety and efficacy

**If applicable add the following information as well:*

My treatment during the study

Submission to the government agencies that may monitor the study

**Describe any other disclosure*

5. Expiration date or event

This authorization expires upon:

- The following date: _____
- End of research study
- No expiration date
- Other: _____

6. Right to revoke authorization

I understand that I have a right to revoke this authorization at any time. My revocation must be in writing in a letter sent to the Principal Investigator at _____ . I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my PHI have already acted in reliance upon this authorization.

7. Statement that re-disclosures are no longer protected by the HIPAA Privacy Rule

I understand that my personal health information will only be used as described in this authorization in relation to the research study. I am also aware that if I choose to share the information defined in this authorization to anyone not directly related to this research project, the law would no longer protect this information. In addition, I understand that if my personal health information is disclosed to someone who is not required to comply with privacy protections under the law, then such information may be re-disclosed and would no longer be protected.

8. Right to refuse to sign authorization and ability to condition treatment, payment, enrollment or eligibility for benefits for research related treatment

I understand that I have a right not to authorize the use and/or disclosure of my personal health information. In such a case I would choose not to sign this authorization document I understand I will not be able to participate in a research study if I do not do so. I also understand that treatment that is part of the research project will be conditioned upon my authorization for the use and/or disclosure of my personal health information to and for use by the research team.

9. Suspension of right to access personal health information

I agree that I will not have a right to access my personal health information obtained or created in the course of the research project until the end of the study.

10. If I have not already received a copy of the University of Missouri Healthcare Privacy Notice, I may request one. If I have any questions or concerns about my privacy rights I should contact, the HS Privacy Officer at 573-882-9054 or the Campus Privacy Officer at 573-882-7254.

11. Individuals' signature and date

I certify that I have received a copy of the authorization.

Signature of Research Participant

Date

Research Participant's Legally Authorized Representative

Date

Describe Representative Authority to Act for the Participant