

**AUTHORIZATION TO USE AND/OR DISCLOSE
YOUR PROTECTED HEALTH INFORMATION
for
RESEARCH STUDY**

This form is intended to tell you about the use and/or disclosure (sharing) of your personal **Protected Health Information** (PHI) if you decide to participate in the research study described below. The health information about you that may be used or disclosed is described on the next page, and this information is usually found in your medical records. Only the health information about you that is needed for this research study will be used or disclosed. When you consider taking part in this research study, you are also being asked to give your permission for your Protected Health Information to be released from your doctors, clinics, and hospitals to the research personnel approved for this research study. This Authorization specifically relates to the research study described below, and should be kept with your copy of the Informed Consent document.

[These numbered items must be completed by the Principal Investigator prior to giving you this form:]

1. Study Protocol # and Title:

2. Principal Investigator: _____

Only the Principal Investigator and research personnel approved by the TTUHSC Institutional Review Board will have access to your PHI, except as described on page two of this Authorization.

3. Name of Study Sponsor:

4. What is this research and why is this research being done? *(This should be a duplicate of the answer to question 1 on the Informed Consent for this Study)*

5. This Authorization is valid until:

- i. _____ End of the Study;
- ii. _____ Date: _____;
- iii. _____ Indefinitely or until such time as legal requirements will allow this Authorization to be destroyed.

6. If you choose to cancel this Authorization, please give notice in writing to:

Name: _____
Department: _____
Texas Tech University Health Sciences Center
Street Address: _____ Mail Stop/Room: _____
City, State Zip: _____
Phone: _____

If you sign this Authorization, the following persons, groups or organizations may rely on this Authorization to disclose your Protected Health Information to the Principal Investigator and other research personnel who are conducting this Study:

- your treating physicians and healthcare providers and their staff,
- associated healthcare institutions and hospitals where you have or may receive care.

While this research study is in progress, the Principal Investigator or research personnel working on this study will inform you whether or not you will be allowed to see the research related health information that is created about you or collected by the research personnel prior to the end of the study. After the study is finished you may request this information as allowed by the TTUHSC Notice of Privacy Practices.

The Protected Health Information that you authorize to be used or disclosed for research purposes may include your current or future health information from some or all of your health records, including:

<ul style="list-style-type: none"> • hospital records and reports • admission history, and physical examination • X-ray films and reports; operative reports • laboratory reports, treatment and test results (including sexually transmitted diseases, HIV or AIDS) • any other Protected Health Information needed by the research personnel listed above. <p>(* use separate form for disclosure of psychotherapy notes)</p>	<ul style="list-style-type: none"> • immunizations • allergy reports • prescriptions • consultations • clinic notes • mental health records • alcohol / substance abuse records
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For the purposes of this study, your Protected Health Information may need to be reviewed or disclosed to individuals or organizations within and/or outside of TTUHSC who sponsor, approve, assist with, monitor or oversee the conduct of research studies. This includes, but is not limited to, the TTUHSC Institutional Review Board, TTUHSC compliance reviews, the US Food and Drug Administration (FDA) or governmental agencies in other countries. Some of these individuals or organizations may share your health information further, and your health information may not be protected by the same privacy standards that TTUHSC is required to meet.

If you choose to sign this Authorization form, you can change your mind about this later. If you change your mind, send a letter to the person identified above telling us to stop collecting and sharing your Protected Health Information. When we receive your request, you may be asked to leave the research study if all the necessary information has not been collected. We may still use the information about you that we have already collected. We need to know what happens to everyone who starts a research study, not just those people who stay in it.

You have the right to refuse to sign this form. If you choose not to sign this form, your regular health care will not be affected. However, not signing this form will prevent you from participating in this research study and prevent you from receiving research related health care services provided under this study.

I have had the opportunity to review and ask questions regarding this Authorization to use or disclose my personal health information, and I will receive a copy of this form. By signing this Authorization, I am confirming that it reflects my wishes.

Signature of Individual or Authorized Representative

Date

Printed Name

If applicable, Relationship of Authorized Representative or Authority to Sign

Witness to Oral Presentation