Health Insurance Portability and Accountability Act (HIPAA) Form

Principal Investigator: _____
Department: _____
Tracking Number: _____

Study Title:

Co-Investigator(s):

Sponsor: _____

Subject's Name: _____
ID Number: _____

We know that information about you and your health is private. We are dedicated to protecting the privacy of that information. Because of this promise, we must get your written authorization (permission) before we may use or disclose your protected health information or share it with others for research purposes. This form gives that permission. It also helps us make sure that you are correctly told how this information will be used or disclosed. Please read the information below carefully before signing this form. Please ask any questions you may have about this form or its uses. You can decide to sign or not to sign this authorization form. However, if you choose not to sign this authorization form, you will not be able to take part in the research study. Whatever choice you make about this research study, it will not have an effect on your access to medical care.

USE AND DISCLOSURE COVERED BY THIS AUTHORIZATION

DO NOT SIGN A BLANK FORM. You or your authorized representative should thoroughly read the information below before signing this form. Who will disclose, receive, and/or use the information? This form will authorize the following person(s), class(es) of persons, and/or organization(s) to disclose, use, and receive the information*:

- The research site(s) carrying out this study.
- This includes UHA or UHA Affiliated, WVU, WVU Hospitals. It also includes each site´s research staff and medical staff.
- Health care providers who provide services to you as part of this research study.
- Laboratories and other people and groups that look into your health information as part of this study in agreement with the study protocol.
- The United States Department of Health and Human Services (which includes the National Institutes of Health, Food and Drug Administration (FDA)) and other groups that have the right to use the information as required by law.

* If, during the course of the research, one of the companies or institutions listed above merges with, or is purchased by, another company or institution, this authorization to use or disclose protected health information in the research will extend to the success or company or institution.

(In this field, please include what information will be disclosed)

Initials Date

SPECIFIC UNDERSTANDINGS

By signing this research authorization form, you give permission for the use and/or disclosure of your protected health information described above. The purpose for the uses and disclosures you are authorizing is to carry out the research study explained to you during the informed consent process. It is also to ensure that the information relating to the research is available to all parties who may need it for research purposes. Your protected health information may be used as necessary for your research related treatment or to collect payment for your research-related treatment (when applicable). It may also be used to run the business operations of the institution. This information may be re-disclosed or used for other purposes if a recipient described in this form is not required by law to protect the privacy of the information.

You have a right to refuse to sign this authorization. Your health care outside the study, the payment for your health care, and your health care benefits will NOT be affected if you do not sign this form. However you will NOT be able to take part in the research study described in this authorization if you do not sign this form. If you sign this authorization, you will have the right to cancel it at any time, except to the extent that UHA or UHA Affiliated, WVU, WVU Hospitals has already taken action based upon your authorization or needs the information to complete analysis and reports of data for this research study. To cancel this authorization, please write to the Principal Investigator, _____, at: Mailbox #:_____.

You will NOT be allowed to see or copy the information described on this form as long as the research is in progress, but you have a right to see and copy the information upon completion of the research in accordance with hospital policies.

The members and staff of any Institutional Review Board (IRB) that oversees this research study.
The Principal Investigator: _____
Members of UHA or UHA Affiliated, WVU, WVU Hospitals, administrative staff responsible for administering clinical trials and other research activities, including the Clinical Trials Office/Office of Research and Sponsored Programs.

You have a right to receive a copy of this form after you have signed it. Expiration Date: _____

THE SUBJECT OR HIS/HER AUTHORIZED REPRESENTATIVE MUST BEPROVIDED WITH A COPY OF THIS FORM AFTER IT HAS BEEN SIGNED.

Initials Date

SIGNATURE

I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above.

[_____]
Signature of Subject or Authorized Representative Date

[_____]
Print Name of Subject or Authorized Representative

[_____]
Relationship of the person signing as Subject or Authorized Representative above to the Subject

[_____]
Print Name of Individual Explaining this Research Authorization Form

CONTACT INFORMATION

The contact information of the subject or authorized representative who signed this form should be filled in below.

Address:

_____
_____
_____
_____

Telephone:

_____ (daytime)
_____ (evening)
_____

E-mail Address (optional): _____

Initials Date