Department

8001 Natural Bridge Road
St. Louis, Missouri 63121-4499
Telephone: 314-516-XXXX
Fax: 314-516-XXXX
E-mail: XXXX@umsl.edu

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 explains how your Protected Health Information will be safeguarded. **Please read carefully to be sure you agree to all of the following statements.**

Description of the Protected Health Information

My authorization applies to the information described below. Only this information may be used and/or disclosed in accordance with this authorization: [Insert a description of the kind of health information your research will generate, or which you will need to obtain from another source.]

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: [List all people (either by name or by staff classification) who will have access to Protected Health Information in the course of your research.]

Who may receive the information

I authorize the following persons (or class of persons) to receive my personal health information: [List all people (either by name or by staff classification) who will collect Protected Health Information in the course of your research.]

Purpose of the use or disclosure of information [Pre-check all which apply.]

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

☐ Auditing
☐ My treatment during the study
☐ Study outcomes including safety and efficacy
☐ Administrative and billing
☐ Submission to government agencies that may monitor the study
☐ Publications and presentation of results that may identify me as a subject
☐ Other: _____

Expiration date or event [Fill in appropriate information.]

This authorization expires upon:

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

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 [insert PI's address] . 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.

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 with 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.

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 sign. 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.

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 expiration of this authorization.

If I have any questions or concerns about my privacy rights I should contact, the HIPAA Compliance Officer at 314-516-5362.

I have read the above statements and have been able to express my concerns, to which the investigator has responded satisfactorily. I believe I understand the purpose of the study, as well as the potential benefits and risks that are involved. I authorize the use of my PHI and give my permission to participate in the research described above. I certify that I have received a copy of the authorization.

All signature dates must match. [Use signatures as appropriate.]

Participant's Signature	Date	Participant's Printed Name	
Parent or Guardian's Signature	Date	Parent or Guardian's Printed Name	
Witness' Signature	Date	Witness' Printed Name	
Researcher's Signature (See guidelines on Who May Obtain Consent)	Date		

The Notice of Privacy Practices (a separate document) describes the procedures used by UM-SL to protect your information. If you have not already received the Notice of Privacy Practices, the research team will make one available to you.

_____ I have been offered a copy of the UM-SL Notice of Privacy Practices.
Initial