UNION UNIVERSITY
INSTITUTIONAL REVIEW BOARD

Authorization for Use/Disclosure of Health Information

What is the purpose of this form? Under federal privacy regulations, you have the right to determine who has access to your personal health information (called "protected health information" or PHI). You are being asked to sign this form so that Union University may use and release your PHI for research**.** Your PHI will be used only for the research purposes described in the Informed Consent. It will not be used or disclosed to any other person or entity, except as required by law, or for authorized oversight of this research study by other regulatory agencies, or for other research for which the use and disclosure of your PHI has been approved by the IRB. Participation in research is voluntary. If you choose to participate in the research, you must sign this form so that your health information may be used for the research.

Participant name: _____

Principal Investigator: _____ Advisor:_____

Name of Study: _____

_____

What health information do the researchers want to use? All medical information and personal identifiers including past, present, and future history, examinations, laboratory results, imaging studies and reports and treatments of whatever kind related to or collected for use in the research protocol.

Why do the researchers want my health information? The researchers want to use your health information as part of the research protocol listed above and described to you in the Informed Consent document.

Who will disclose, use and/or receive my health information? The physicians, nurses and staff working on the research protocol (whether at Union University or elsewhere); other operating units of Union University, the IRB and its staff; the sponsor of the research and its employees; and outside regulatory agencies, such as the Food and Drug Administration.

How will my health information be protected once it is given to others? Your health information that is given to the study sponsor will remain private to the extent possible, even though the study sponsor is not required to follow the federal privacy laws. However, once your information is given to other organizations that are not required to follow federal privacy laws, we cannot assure that the information will remain protected.

How long will this Authorization last? Your authorization for the uses and disclosures described in this Authorization does not have an expiration date.

Can I cancel the Authorization? You may cancel this Authorization at any time by notifying the Chair of the IRB, in writing, referencing the Research Protocol and IRB Protocol Number. If you cancel this Authorization, the study doctor and staff will not use any new health information for research. However, researchers may continue to use the health information that was provided before you cancelled your authorization.

Can I see my health information? You have a right to request to see your health information. However, to ensure the scientific integrity of the research, you will not be able to review the research information until after the research protocol has been completed.

Signature of participant: _____ Date: _____

or participants' legally authorized representative: _____ Date: _____

Printed Name of participant's representative: _____

Relationship to the participant: _____