###### **HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)**

###### **AUTHORIZATION TO OBTAIN, USE, AND DISCLOSE**

**PROTECTED HEALTH INFORMATION FOR RESEARCH**

**Name of Study Subject:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Medical Record Number: \_\_\_\_\_\_\_\_\_\_\_\_**

**Name of this Research Study:** *<Title>*

**UMB IRB Approval Number:** *<IRB number>*

Researcher’s Name: *<PI name>*

Researcher’s Contact Information:

*<Department / Institution name>*

***University of Maryland School of Medicine (UMSOM)***

*<Street Address>, <Room number>*

*<Phone number>*

**This research study will use health information that identifies you. If you agree to participate, this researcher will use just the health information listed below.**

The Specific Health Information To Be Used or Shared:

Delete any bulleted items below that do not apply. Replace *[Specify others if applicable] with* any additional information that may be obtained from participants that is not listed below.

* Billing and payment information and the medical information required to justify it
* Information that relates to your health or medical condition from your medical records
* Information obtained from the study procedures outlined in this Authorization, including:
  + Laboratory results obtained on specimens collected from you (blood, urine, or tissue)
  + Results of physical exams and other tests or procedures
  + Any other medical information we learn from you about your health history
  + Interviews, questionnaires, or surveys
* *[Specify others if applicable]*

Federal laws require this researcher to protect the privacy of this health information. The researcher will share it only with the people and groups described here.

People and Organizations Who Will Use or Share This Information:

Delete any bulleted items below that do not apply. Replace *[Specify others if applicable]* withany additional people and organizations not listed below.

* Dr. *< PI name >* and the study team
* Other researchers and centers that are part of this study, including people who oversee research at those institutions
* People or groups hired to provide services related to this research (i.e., service providers, laboratories, etc.)
* The sponsor of the study or its agents, such as data repositories or contract research organizations
* Organization(s) that will coordinate health care billing or compliance such as offices within UMSOM; the University of Maryland, Baltimore (UMB); University of Maryland Faculty Physicians, Inc. (FPI) and the faculty practices of the UMB; University of Maryland Medical System (UMMS) and the Veterans Affairs Maryland Health Care System (VAMHCS)
* Your health insurer to pay for covered treatments outlined in the Cost to Subject section of Research Consent form
* [Specify others if applicable]

**This Authorization Will Not Expire. But You Can Revoke it at Any Time**.

To revoke this Authorization, send a letter to this researcher stating your decision. The researcher will stop collecting health information about you. This researcher might not allow you to continue in this study. The researcher can use or share health information already gathered.

**Additional Information:**

* You can refuse to sign this form. If you do not sign it, you cannot participate in this study. This will not affect the care you receive at:
  + University of Maryland Faculty Physicians, Inc. (FPI)
  + University of Maryland Medical System (UMMS)
  + Veteran Affairs Maryland Health Care System (VAMHCS)

It will not cause any loss of benefits to which you are otherwise entitled.

* Sometimes, government agencies such as the Food and Drug Administration or the Department of Social Services request copies of health information. The law may require this researcher, the UMSOM, FPI, UMMS, or VAMHCS to give it to them.
* This researcher will take reasonable steps to protect your health information. However, federal protection laws may not apply to people or groups outside the UMSOM, UMB, FPI, UMMS, or VAMHCS.
* Except for certain special cases, you have the right to a copy of your health information created during this research study. You may have to wait until the study ends. Ask the researcher how to get a copy of this information from the study.

My signature indicates that I authorize the use and sharing of my protected health information for the purposes described above. I also permit my doctors and other healthcare providers to share my protected health information with this researcher for the purposes described above.

Subject’s Signature Date Printed Name

Signature of Parent/Guardian/LAR Date Printed Name  
*(When applicable)*

Relationship to Subject:

Privacy Questions? Call the UMSOM Privacy Official (410-706-0337) with questions about your rights and protections under privacy rules.

Other Questions? Call the researcher named on this form with any other questions.