Southern Illinois University Edwardsville
Institutional Review Board

Authorization To Use and Disclose Protected Health Information for Research Purposes

The privacy law, Health Insurance Portability & Accountability Act (HIPAA), protects your individually identifiable health information (protected health information). The privacy law requires you to sign an authorization (or agreement) in order for researchers to be able to use or disclose your protected health information for research purposes in the study entitled "TITLE HERE."

You authorize RESEARCHER'S NAME HERE to use and disclose your protected health information for the purposes described below.

Your protected health information that may be used and disclosed includes:

Medical records for resident's LIST DATA TO BE COLLECTED HERE

The Researchers may use and share your health information with:

- *Southern Illinois University at Edwardsville's Institutional Review Board (SIUE's IRB)*
- *LIST ADDITONAL INTITIES HERE:*

The researcher agrees to protect your health information by using and disclosing it only as permitted by you in this Authorization and as directed by state and federal law.

Should the health information be disclosed by the researcher, to someone outside of this study, it may be subject to re-disclosure and may no longer be covered/protected by the federal privacy protections.

You do not have to sign this Authorization. If you decide not to sign the Authorization:

- It will not affect your treatment payment or enrollment in any health plans or affect your eligibility for benefits.
- you may not be allowed to participate in the research study.

After signing the Authorization you can change your mind and:

- Not let the researcher disclose or use your protected health information (revoke the Authorization).
- If you revoke the Authorization, you will send a written letter to: RESEARCHER'S NAME HERE to inform her/him of your decision.
- If you revoke this Authorization, researchers may only use and disclose the protected health information already collected for this research study.
- If you revoke this Authorization your protected health information may still be used and disclosed should you have an adverse event (a bad effect).
- If you change your mind and withdraw the authorization, you may not be allowed to continue to participate in the study.

Optional item: 1 understand that 1 will not be allowed to review the information collected for the research until after the study is completed. When the study is over, 1 will have the right to access the information again.

This Authorization does not have an expiration date.

If you have not already received a copy of the Privacy Notice, you may request one. If you have any questions or concerns about your privacy rights as a study participant, you should contact the Southern Illinois University Edwardsville Institutional Review Board (SIUE IRB) at:

Taylor Welch
Southern Illinois University Edwardsville
researchcompliance@siue.edu
Telephone number: (618) 650-3010

You are the subject or are authorized to act on behalf of the subject. You have read this information, and you will receive a copy of this form after it is signed.

_____ _____

Signature of research subject or research subject's legal representative | **Date**

_____ _____

Printed name of research subject or research subject's legal representative | **Representative's relationship to research subject**

Please explain Representative's relationship to Patient and include a description of Representative's Authority to act on behalf of Patient:

_____
_____
_____
_____

NOTICE OF REVOCATION

I, _____ hereby revoke my authorization of this disclosure of information expressly given by the above authorization. I understand that any actions based on this authorization, prior to revocation, will not be affected.