**HIPAA Authorization**

Federal law provides additional protections of your medical records and related health information.

I agree to permit the Principal Investigator [name] and research staff (“Researchers”) [and study sponsor, the sponsor of this study,] may use and disclose health information that identifies me for the purposes described below. I also agree to permit Parkview Health and its affiliates, [name of any other institutions,] my doctors, and my other health care providers may disclose health information in my medical records to the Researchers [and to study sponsor] for the purposes described below.

1. The health information that may be used and disclosed includes:

* all information collected during the research described in the Informed Consent Form; and
* health information in your medical records that is relevant to the research described in the Informed Consent Form.

2. The Researchers may:

* use and share my health information to conduct the research;
* [disclose my health information to the sponsor of the research, [study sponsor]and its agents;]
* disclose my health information to Parkview Health and its affiliates;
* disclose my health information as required by law;
* disclose my health information to representatives of government organizations and other persons who are required to watch over the safety and effectiveness of medical products and therapies and the conduct of research; and
* remove from my health information my name and other information that could be used to identify me.

3. [Study Sponsor may:

* use and share my health information to conduct the research;
* use my health information as described in the Informed Consent;
* disclose my health information as required by law;
* disclose my health information to representatives of government organizations and other persons who are required to watch over the safety and effectiveness of medical products and therapies, and the conduct of research; and
* remove from my health information my name and other information that could be used to identify me.]

4. Once information that could be used to identify me has been removed, the information that remains is no longer subject to this Authorization and may be used and disclosed by the Researchers [and Study Sponsor] as permitted by law.

5. Once my health information has been disclosed to a third party, federal privacy laws may no longer protect it from further disclosure. However, the Researchers [and study sponsor] agree to protect your health information by using and disclosing it only as permitted by me in this Authorization and the Informed Consent. Also, no publication about the research will reveal my identity without my specific written permission. These limitations continue even if I revoke (take back) this Authorization.

6. Please note that:

* You do not have to agree to this Authorization, but if you do not, you may not be allowed to participate in the research.
* You may change your mind and revoke this authorization at any time. To revoke this Authorization, you must write to [Principal Investigator at address]. However, if you revoke this Authorization, you may no longer be allowed to participate in the research. Also, even if you revoke this Authorization, the information already obtained by the Researchers [and study sponsor] may be used and disclosed as permitted by this Authorization and the Informed Consent.
* While the research is in progress, you will not be allowed to see your health information that is created or collected in the course of the research. After the research is finished, however, you may see this information as described in Parkview’s Notice of Privacy Practices.

7. This Authorization will expire 50 years from the date of signature.

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Parent/Guardian/Legal Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient (if not self):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_