**Virginia Commonwealth University Health System (****VCU Health)**

**Research Subject** **HIPAA Authorization Form**
**for Use or Disclosure of Protected Health Information (PHI)**
**(In accordance with HIPAA Act 45** **CFR 160 and 164)**

Research study title:

RAMS-IRB number:

**What is the purpose of this form?**

Federal privacy laws protect the use and release of your protected health information (“PHI”). Under these laws, VCU Health cannot release your protected health information for research purposes unless you give your permission. Your information will be released to the research team, which includes the researchers, people hired by VCU Health or the sponsor to do the research, and people with authority to oversee the research. If you decide to give your permission and participate in the study, you must sign this form and the Consent Form. This form describes the different ways that VCU Health can share your information with the researcher, research team, sponsor, and people with oversight responsibility. The research team will use and protect your information as described in the Consent Form. However, once your health information is released by VCU Health, it may not be protected by federal privacy laws and might be shared with others. If you have questions, ask a member of the research team.

By signing this form, you give us permission to use or disclose your requested PHI (itemized below) for the conduct and oversight of the above-mentioned research study.

**What Personal Health Information will be released?**

If you give your permission and sign this form, you are allowing **VCU Health** to release the following medical records containing your Personal Health Information. Your Personal Health Information includes health information in your medical records, financial records and other information that can identify you.

* Entire Medical Record
* Inpatient Records
* Progress Notes
* Consultation
* Discharge Summary
* History & Physical Exams
* Operative Reports
* Abstract of Record\*

\* An abstract of the record includes: History & Physical Exams, Operative Reports, Consultation and Discharge Summary Reports, and Diagnostic Reports (including Lab, Pathology, & Imaging).

The information used/disclosed pursuant to this authorization will not include psychotherapy notes, but may include detailed mental health information, HIV/AIDS information and/or information regarding alcohol or substance abuse consistent with 42 CFR 2.52.

* Lab & Pathology Reports
* Radiology Reports
* Psychological Tests
* Other Test Reports
* Emergency Dept. Records
* Outpatient/Ambulatory Clinic Records
* Radiology Images
* Diagnostic Photographs, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Financial records
* Other (describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**People that will Use or Disclose your PHI:** the following person(s), class(es) of persons, and/or organization(s) may disclose, use, and receive the information, but they may only use and disclose the information to the other parties on this list, to the research subject or his/her personal representative, or as otherwise permitted or required by law.

* The Principal Investigator and the research staff and any other people and groups authorized to help conduct the study.
* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the study sponsor for this research study. The sponsor may also use your PHI to collect and analyze the results of the research and may have other people and groups help conduct, oversee, and analyze the study. These people will use your PHI.
* Every health care provider who provides services to you in connection with this study.
* Any laboratories and other individuals and organizations that analyze your health information in connection with this study in accordance with the study’s protocol.
* The Virginia Commonwealth University Institutional Review Board.
* Any government agencies that regulate research including: the Office for Human Research Protections, The Food and Drug Administration, Medicare, Medicaid, and other regulatory agencies.
* Data and Safety Monitoring Boards / Ethics Committees, research monitors and reviewers.
* Others, specify:

You do not have to sign this authorization form. If you do not sign, you may not participate in the above-mentioned research study. VCU Health providers shall not condition treatment on the receipt of this authorization, and you may still receive non-research related treatment. This Authorization to release your personal health information expires when the research ends, and all required study monitoring is over.

**Revoking your Authorization:**

You may change your mind and revoke (take back) this Authorization at any time. If you revoke your authorization, the researchers will not collect any more of your PHI. But they may use or pass along the information you already gave them so they can follow the law, protect your safety, or make sure the research is done properly. The information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient of the information and may then no longer be protected by the federal privacy regulations. This authorization for use and disclosure for research purposes indicated above is valid until the end of the study or until/unless you revoke this authorization**.**

If you do wish to revoke authorization you must write to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

**Participant**

If you agree to the use and release of your Personal Health Information, please print your name and sign below. You will be given a signed copy of this form**.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Participant's Name (print)--*required*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Participant’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date

**Parent or Legally Authorized Representative**

If you agree to the use and release of the above-named Participant's Personal Health Information, please print your name and sign below.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent or Legally Authorized Representative’s name (print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent or Legally Authorized Representative’s Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date

**Witness**

***If this form is being read to the Participant because they cannot read the form, a witness must be present and is required to print their name and sign here:***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness’ Name (print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness’ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date

**Interpreter**

***This section must be completed if an interpreter is used during the authorization process because the subject does not speak English.***

By signing below, you confirm that the information in this form has been fully explained to the potential subject in a language they understand and all their questions have been answered.

***If the interpreter speaks with the participant over the phone, write the interpreter's ID # on the signature line below.***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Interpreter Name (print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Interpreter’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date