SAMPLE HIPAA RESEARCH AUTHORIZATION

*** Insert information where requested (e.g., [name of research institution]).**

Authorization for the Disclosure and Use of Your Health Information

By signing this authorization form, you are authorizing [name of research institution], including the Principal Investigator [name of Principal Investigator], and other members of the research staff, to use and disclose your health information for the following purposes: [describe purposes of uses or disclosures], and as otherwise needed for the research study. This health information includes [describe information as specifically as possible], and any other health information relating to this research study.

Your health information may be disclosed to [name of research sponsor], the sponsor of this research; Institutional Review Boards that review this research to make sure that it is ethical; and state and federal government agencies, including, but not limited to, the Food and Drug Administration (FDA), the Department of Health and Human Services, and the Department of Defense [name any other person(s)/organizations to whom information may be disclosed]. Health information that has been disclosed may be re-disclosed by the recipient of the information.

[Include one of the following: (1) "There is no expiration date for this authorization" or (2) "This authorization expires when [insert an expiration date or expiration event that relates to the individual or the purpose of the use or disclosure. For example, "the FDA grants final approval of the tested product, or upon final publication of the results of the research, whichever event comes later."]

You have the right to revoke this authorization in writing, unless [research institution] has already taken action relying on this authorization. You may revoke this authorization by writing to the Principal Investigator at [address].

Any medical treatment that is to be provided as part of this research study will be provided only if you authorize the uses and disclosures of your health information as described.

[Insert if necessary for the research: "[Research institution] will not disclose your health information to you during the course of the research study. You may request copies of records containing your health information after the research is completed."]

If you have not already received a copy of the Military Health System Notice of Privacy Practices, you may request one. If you have any questions or concerns about your privacy rights, you should contact [name of and contact information for appropriate privacy officer].

You will receive a copy of this form after it is signed.

____________________________ __________________

Volunteer’s Signature or Personal Representative — Date

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Volunteer’s Printed Name or Personal Representative