BROOKE ARMY MEDICAL CENTER/WILFORD HALL MEDICAL CENTER
AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION FOR RESEARCH
(APHI Template Version 1, Apr 03)

You are being asked for permission to use or disclose your protected health information for research purposes in the research study entitled *[Insert title of study].*

The Privacy Law, the Health Insurance Portability & Accountability Act (HIPAA), protects your individually identifiable health information (protected health information). This 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 listed above.

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

- *[Demographic Information for example age, sex, race, etc.]*
- *[Medical History/Surgical History]*
- *[Imaging Studies, Laboratory Results]*
- *[Other: List all other information that may be accessed, disclosed or otherwise included in research activities.]*

Your protected health information will be used for:

- *[Provide a brief description of each research project or paste information from the purpose section in the consent form.]*

The disclosure of your protected health information is necessary in order to be able to conduct the research project described. Records of your participation in this study may only be disclosed in accordance with federal law, including the Federal Privacy Act, the Health Insurance Portability and Accountability Act of 1996, 5 U.S.C.552a, and its implementing regulations. DD Form 2005, Privacy Act Statement - Military Health Records, contains the Privacy Act Statement for the records. Note: Protected health information of military service members may be used or disclosed for activities deemed necessary by appropriate military command authorities to ensure the proper execution of the military mission.

By signing this authorization, you give your permission for information gained from your participation in this study to be published in medical literature, discussed for educational purposes, and used generally to further medical science. You will not be personally identified; all information will be presented as anonymous data.

The Principal Investigator may use and share your health information with:

- The BAMC/WHMC Institutional Review Board
- Government representatives, when required by law
- BAMC, WHMC or Department of Defense representatives
- *[List any collaborators, outside laboratories, etc.]*
- *[If applicable -list the sponsor's name]*
- *[List any other groups with whom the information may be shared]*

The researchers *[and list sponsor's name, foundations, etc if applicable]* agree 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.

If your protected health information is disclosed to anyone outside of this study, the information may no longer be protected under this authorization.

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:

- Notify the researcher that you have withdrawn your permission to disclose or use your protected health information (revoke the Authorization).
- If you revoke the Authorization, you will send a written letter to *[Principal Investigator's name and contact information]* to inform him/her 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 withdraw the Authorization, you may not be allowed to continue to participate in the study.

This Authorization does not have an expiration date.

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 the Brooke Army Medical Center Privacy Officer at phone number (210) 916-1029 or Wilford Hall Medical Center Privacy Officer at (210) 292-4617.

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.

Volunteer's Signature or Legal Representative	**Volunteer's SSN**	**Date**
Volunteer's Printed Name or Legal Representative	**Sponsor's SSN**	
Relationship of Legal Representative to Volunteer		
Signature of Witness		**Date**