

**Docket Number: Hxxx**

**Please complete this form if you would like someone to contact you about the research.**

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

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Telephone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Best way to contact you (over the phone, over email): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize the UMass Memorial Medical Center to disclose the protected health information on this form to:

* University of Massachusetts Medical School including the researcher \_\_\_\_\_\_\_\_\_ and her research staff
* Federal and State authorities that oversee research

The research team will use the information to contact me with more information about the study.

I do not have to sign this Authorization. If I decide not to sign, it will not affect my treatment, payment or enrollment in any health plans, or affect my eligibility for benefits. This authorization does not have an expiration date. I have the right to revoke this authorization at any time by sending a written letter to \_\_\_\_<PI’s contact info>\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.If I revoke this Authorization, researchers may only use the protected health information already collected for this research study. Any disclosure carries the potential for re-disclosure. Once my protected health information is released, it may no longer be protected by the HIPAA privacy rule. I will sign two copies of this form and keep one copy for my records.

**Give a copy of this signed authorization to the potential research subject and give a copy to the researchers for their study files.**