**AUTHORIZATION TO DISCLOSE**

**PROTECTED HEALTH INFORMATION FOR RESEARCH PURPOSES**

The privacy law, Health Insurance Portability & Accountability Act (HIPAA), protects my individual identifiable health information (Protected Health Information, or PHI). The privacy law requires me to sign an authorization (or agreement) in order for researchers to be able to use or disclose my protected health information for research purposes in the study entitled:

*[Insert docket # and study title]*

I authorize UMass Memorial Medical Center or any other healthcare facility where I may be treated to disclose my protected health information to:

* The researcher *[insert name of PI]* and their research staff
* Federal and State authorities that oversee research
* The sponsor of the research *[Insert Name of Sponsor or delete this bullet if the research has no external funding]*
* People and companies who work with the research sponsor *[Delete this bullet if the research has no external funding]*
* The Institutional Review Board (IRB) that reviewed this research*[Delete if not using an external IRB]*
* The UMass Chan Medical School and UMass Memorial Health, including their Institutional Review Board (IRB) and research, billing, and compliance offices *[Delete billing if this office does not apply]*
* Health care providers who provide services in connection with this study
* People and companies who work with UMass Chan and UMMH on activities related to the research
* List others with whom private information will be shared *[Or delete this bullet]*

**Protected Health Information (PHI) that may be disclosed includes all boxes below marked with an “X”, and PHI which is listed in the sections titled “Other” below.**

*[To select a box, double click on the box and change the default value to Checked.]*

|  |  |
| --- | --- |
| **General Records** | |
| Cardiac Studies (Heart) | Laboratory Reports |
| Consultations | Office/Clinic Notes |
| Discharge Summaries | Operative/Procedure Reports |
| EEG/EMG/Sleep Studies | Pathology Reports |
| Emergency Service Records | Problem List |
| Home Health Records | Pulmonary Studies (Lung/Respiratory) |
| Hospice Records | Radiology (X-ray/CAT/MRI/Ultrasound/Nuclear) |
| Immunization Records | Rehabilitation Notes (PT/OT/Speech) |
| **Other (Specify):** | |
| **Statutorily Protected Records** | |
| Abortion | Domestic Violence Counseling |
| Alcohol/Drug Abuse | HIV/AIDS Test Results/Treatment |
| Psychiatric Health | Sexually Transmitted Diseases |
| Sexual Assault Counseling | Genetic Testing Information |
| **Other (Specify):** | |

**My protected health information will be disclosed as listed above for the following reasons:**

* To conduct research *[Add a brief description of the research using everyday language]*

**I do not have to sign this Authorization. If I decide not to sign the Authorization:**

* It will not affect my treatment, payment or enrollment in any health plans, or affect my eligibility for benefits.
* I will not be allowed to participate in the research study.

**If I sign the Authorization, I understand that:**

* I have the right to withdraw, or revoke the Authorization.
* If I revoke the Authorization, I will send a **written** letter to ***[insert PI name and mailing address]*** to inform them of my decision.
* If I revoke this Authorization, researchers may only use the protected health information **already** collected for this research study.
* If I revoke this Authorization my protected health information may still be used and disclosed should I have an adverse event (a bad effect).
* If I change my mind and withdraw the Authorization, I will not be allowed to continue to participate in the study.
* Any disclosure carries the potential for re-disclosure. Once my protected health information is disclosed, it may no longer be protected by the HIPAA privacy rule.
* The entities receiving my protected health information will use it as described in the Consent Document for this study.
* I may not be allowed to review some of the research-related information in my medical record until after the study is completed. When the study is over, I will have the right to access the information again.
* In the event that I die while enrolled in the study, all medical records related to my treatment and death at any healthcare facility will be released to **[insert PI name]** and their research staff. **[Delete this bullet if not applicable]**
* I will receive a signed copy of this authorization for my personal records.

This Authorization does not have an expiration date.

If I have questions about the research study, I should contact ***[insert name of PI here] at [insert phone #]***.

If I have not already received a copy of the Privacy Notice, I may request one. If I have any questions or concerns about my privacy rights, I should contact the UMass Memorial Medical Center Privacy Officer at the phone number 508-334-5551.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS AND AUTHORIZE THE DISCLOSURE OF THE INFORMATION REQUESTED ABOVE

|  |  |
| --- | --- |
| Signature of Subject | Date |
| Subject Name (Printed |  |

**Use boxes below if parent or legal representative is signing for research subject**

|  |  |  |
| --- | --- | --- |
| Subject’s Legal Representative Signature | Relationship | Date |

|  |
| --- |
| Print Name of Legal Representative |

Please explain Representative Relationship to Subject and include a description of Representative’s Authority to act on behalf of Subject:

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|  |  |
| --- | --- |
| Person obtaining HIPAA Authorization | Date |

**NOTE TO PI:**

**Forward the original signed authorization to:**

**Health Information Management – Room HB 354**

**UMass Memorial Medical Center**

**55 Lake Avenue North**

**Worcester, MA 01655**

**Give a copy of the signed authorization to the research subject, and keep a copy for the study files.**