I am interested in having a member of the study team contact me to learn more about their research study.

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

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Which is the best time to call you? (circle one): AM PM either

Is it OK to leave a voice message? (circle one): yes no

Is it OK to text a message to the number above? (circle one): yes no

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

I do not have to agree to this authorization. The information on this form may be shared with individuals and organizations that conduct or watch over this study. Saying no will not affect my treatment, payment, or enrollment in any health plans, or affect my eligibility for benefits. This authorization does not expire. I have the right to revoke this authorization by calling or writing:

PI Name

Address

Phone

If I revoke this authorization, the researchers may only use the protected health information on this form if needed to maintain the reliability of the research. 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 have been provided a second copy of this form for my personal records.

\*Treating clinician or staff, please fax this form to xxx at xxx-xxx-xxxx. Thank you.