Research Authorization for Access to Protected Health Information

Subject Name_____

Study Name_____

Principal Investigator's Name and Contact Information _____

_____

Date _____

To the Subject:

We understand that information about you obtained in connection with your health care is personal, and we are committed to protecting the privacy of the information. Because of this commitment, we wish to obtain your special authorization before we use or disclose your identifiable health information for the research purposes described below. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed. Please read the information below carefully before signing this form. If you have any questions about this authorization, please ask _____ **(PI)** before signing this form.

By signing this research authorization form, you authorize the use and/or disclosure of the information described below, for this research study. The purpose for the uses and disclosures you are authorizing is to _____ **(insert brief description of study**) and to ensure that the information relating to that research is available to all parties who may need it for research purposes.

All health care providers are required to protect the privacy of your information. Your information may be re-disclosed if the recipient(s) described on this form are not required by law to protect the privacy of the information. Once protected health information is disclosed, it is subject to re-disclosure by the recipient, and no longer can be considered protected.

You have a right to refuse to sign this authorization. Your health care outside the study, the payment for your health care, and your health care benefits will not be affected if you do not sign this form, but you will not be able to enroll in the research study described in this authorization and will not receive treatment as a study participant if you do not sign this form. In particular, your refusal to participate will not jeopardize your present or future health care treatment at Griffin Hospital.

If you sign this authorization, you may change your mind at any time, but the researchers may continue to use information collected before you changed your mind to complete the research.

This authorization will never expire unless and until you change your mind and revoke it. To revoke this authorization, please write to _____(**PI)** at _____**(insert address).**

[Optional - only for research that includes treatment as part of the protocol]
You will not be allowed to see or copy the portion of your medical records that describe a research treatment until the research is completed, but you may see and copy the research treatment information at the end of the research in accordance with Griffin Hospital medical record policies.

You have a right to receive a copy of this form after you have signed it. If, after you have signed this form, you have any questions regarding your rights as a study subject, please contact Dr. Brian Karsif, Chairman of the Institutional Review Board of Griffin Hospital at 203-732-1447. In addition, if you believe that your privacy rights have been violated, you have the right to contact or file a complaint with Griffin Hospital's Privacy Officer, Edward J. Berns, Esq., in writing at 130 Division Street, Derby, CT 06418, or by telephone at [203] 732-7506

Use and Disclosure Covered By This Authorization

Who will disclose, receive and/or use the information?

The following person(s), class(es) of persons and/or organization(s) may share, use and receive information listed below in connection with this study. These persons may only use and disclose the information to the other parties on this list, to you or your personal representative, or as required by law.

- ❑ The following health care facilities or research site(s) and research staff involved in this study:
  _____
  _____
- ❑ Health care providers who provide services to you in connection with this study
- ❑ Laboratories and other individuals and organizations that analyze your health information in connection with this study, in accordance with the study's protocol
- ❑ The following research sponsors:_____
- ❑ The United States Food and Drug Administration
- ❑ The members and staff of the Griffin Hospital Institutional Review Board
- ❑ The Principal Investigators and other investigators listed on the front of the study protocol
- ❑ The Study Coordinator
- ❑ Additional members of the study team:_____
  _____
- ❑ Contract research organization _____
- ❑ Data and Safety Monitoring Boards and other authorized to monitor the conduct of the study: _____
- ❑ Others_____
  _____

What personal health information will be used or disclosed?

The following information about you may be used and disclosed:

- ❑ Research study records
- ❑ Medical and laboratory records of only those services provided in connection with this study
- ❑ The entire research record and any medical records held by Griffin Hospital created from _____to_____.
- ❑ The following specific information:

  _____

  _____

Signature

I have read this form and all of my questions about this form have been answered. By signing below, I authorize the described uses and disclosures of information.

_____

Signature of Subject or Personal Representative

_____

Print Name of Subject or Personal Representative

_____

Date

_____

Description of Personal Representative's Authority

Contact Information

The contact information of the subject or personal representative who signed this form should be filled in below:

Address	Telephone
_____	_____ (daytime)
_____	_____ (evening)
_____	_____ (email)

The subject or his/her personal representative must be provided with a copy of this form after it has been signed.

2016-07-07