

**SINAI HEALTH SYSTEM
AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION FOR
RESEARCH**

(Enter Title of Research Study)

Name of Principal Investigator: _____
Department: _____

Dear Patient,

Your signature on this document allows _____ **(name of investigator & department)** and their research staff to use and disclose protected health information (PHI) that identifies you for the research purposes described in this document.

Your Rights

You may choose whether or not to participate in this study. However, in order to participate in this research study, you have to sign the **consent form** and this authorization form. If you decide not to sign this authorization form it will not affect your treatment, payment or enrollment in any health plans or affect your eligibility for benefits.

Description of Information

The protected health information that may be used and disclosed includes all protected health information in your medical records that is related to the research including illnesses and hospitalizations that occur during the research study (please refer to consent form). The health information includes the following:

- Complete health record(s), including all images (x-rays, photographs, etc.)
- Complete health record(s), excluding all images

OR

Select from the following (check as many as apply):

- | | |
|--|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> History and Physical Examination | <input type="checkbox"/> Laboratory Tests |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> X-ray reports |
| <input type="checkbox"/> AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection | |
| <input type="checkbox"/> Mental health care or services | |
| <input type="checkbox"/> Psychotherapy Notes | |
| <input type="checkbox"/> Treatment for alcohol and/or drug abuse | |
| <input type="checkbox"/> Photographs, videotapes, digital or other images | |
| <input type="checkbox"/> Other (please specify) _____ | |

1 Sinai Health System Institutional Review Board
Authorization Form, 3/18/03
Date Approved: _____
IRB Chair, Signature: _____
c:\temp\authorizationform.doc

This information is to be disclosed to the following individuals or entity for the purpose of the research study:

Name	Address	Title	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Others who will have access to your information for this project include:

- Institutional Review Board;
- Sponsor/Agent of the study (insert name) a required for the research and if further information is needed to confirm the research;
- Authorized staff that conduct quality assurance, treatment, billing and ensure the integrity of the project. In the event of an adverse event, your entire medical record may be reviewed.; and
- Representatives of government agencies (i.e., Food and Drug Administration) where required by law.

Information disclosed to groups outside Sinai Health System may no longer be covered by this Authorization and federal privacy regulations.

De-Identification of Information

Sinai Health System may de-identify your information (remove all identifying information) Once the information that identifies you is removed, the information that remains is no longer subject to this authorization and may be used and disclosed for other research purposes.

(Optional)

“Your protected health information is being collected and maintained as part of a database or data repository. This Authorization will not expire at the end of the research study unless you revoke (take back) your Authorization before the research study ends.”

Expiration Date

This Authorization **(does not have an expiration date, expires at the end of the study, or insert specific date)**, but can be terminated if you decide to withdraw your permission.

²Sinai Health System Institutional Review Board
Authorization Form, 3/18/03
Date Approved: _____
IRB Chair Initials: _____

Revoke (Take Back) Authorization

You may revoke (take back) this authorization in writing at any point during the study. To take back this Authorization, you must write to: _____ ***(Insert Principal Investigator Name and Address)***. However, if you revoke this Authorization, you may no longer be allowed to continue participation in the research study. In addition, researchers may still use and disclose health information they already have collected for the research study.

If you have not already received a copy of the Notice of Privacy Practices, please request one.

Signature of Subject or Legally Authorized Representative

I have read (or someone has read to me) the above information. I have been given an opportunity to ask questions and my questions have been answered to my satisfaction. I authorize the use and disclosure of my protected health information for this research study.

Signature of Subject

Date

Printed Name of Subject

Signature of Parent/ Guardian or Legally Authorized Representative of Subject

Date (Must be same as Subjects

Printed Name of Parent/ Guardian or Legally Authorized Representative of Subject

Please describe the relationship to the Subject including the legal authority this individual has to act on behalf of the Subject.

You may refuse to sign this authorization form.

This authorization form will be filed with your secured research records.

³Sinai Health System Institutional Review Board
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**INSTRUCTIONS FOR
SINAI HEALTH SYSTEM
AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION
TEMPLATE**

ALL researchers must obtain an authorization form from all participants enrolled in a study on or after April 14, 2003. You may use this template or combine a consent form and authorization form. The completed template or combined consent/authorization form must be forwarded to Sinai Health System's IRB for approval.

1. All research staff using protected health information (PHI) within Sinai Health System for research purposes must comply with the Health Insurance Portability and Accountability Act (HIPAA). Protected Health Information refers to any information that identifies a patient.
2. HIPAA requires all researchers to obtain a signed authorization form in addition to the informed consent form.

USING THE TEMPLATE

1. If you have an IRB approved study (prior to April 14, 2003) that is enrolling participants, please use the attached template to prepare an authorization form. Your completed form must be forwarded to the IRB office by April 12, 2003.
2. If you have are submitting a new protocol or applying for renewal, please use the template to prepare an authorization form (you may submit a combined **authorization/consent form**).

COMPLETING THE TEMPLATE

1. The authorization form must be written in language easily understood by research subjects.
2. Please follow the template instructions and remove language that does not apply to your study.
3. Do NOT modify the text without approval by the IRB.

QUESTIONS?

Please contact the IRB office at 773-257-6167 with any questions or concerns.

Thank You