Permission to Use, Create and Share Protected Health Information for Research

The federal Privacy Rule protects your health information. The Privacy Rule is part of the Health Insurance Portability and Accountability Act (HIPAA). If you agree to participate in this study, the researchers may use, create or share your health information as part of the research. The researchers will only do so if they have your express permission.

Instructions: This authorization should be attached to the Consent Form.

Title of Study:
Name of Investigator:
Email Address:

This authorization is voluntary and you may refuse to sign this authorization. If you refuse to sign this authorization, your care and relationship with Seven Hills Foundation will not be affected. However, you will not be able to enter this research study.

This form authorizes the Foundation to use and disclose certain protected health information (PHI) about (Name of Subject)____ that we will collect and create in this research study. The description of the information to be used or disclosed and the purposes of the requested use or disclosure are indicated below.

The persons who are authorized to use and disclose your PHI are:

☐ All investigators listed on the Consent Form and others at the Foundation who are participating in the conduct of the research protocol.
☐ The Foundation's Institution Review Board.
☐ Others:

The persons who are authorized to receive this information are:

☐ The sponsor of this study:
☐ Federal or other government agencies as required for their research oversight and public health reporting in connection with this study such as:

We may continue to use and disclose PHI that we collect from you in this study until:

☐ The Health Insurance Portability and Accountability Act (HIPAA) Research Authorization expires. Expiration Date:
☐ The study is completed. Completion Date:
☐ Indefinitely
☐ Other:

While this study is still in progress, you may not be given access to medical information about you that is related to the study until after the research is complete. After the study is completed and the results have been analyzed, you will be permitted access to any medical information collected about you in the study that is maintained in your medical record.

You may withdraw, at any time, your permission to provide this information to the researchers. However, once this information has been shared with the researchers, the information will be in their possession. To withdraw your permission, you will need to take the following course of action:

You should send a written and dated notice of this decision to the principal investigator of this research study at the email address listed above. Upon receipt of this request, the researchers will withdraw your information from the study.

Your decision to withdraw your permission to provide this information to the researchers will have no effect on your current or future medical care or your relationship with the Foundation, your program or health care provider.

Description of the information to be used or disclosed and the purposes of the requested use of disclosure:

Health Information

☐ Your complete existing health record.
☐ Limited information from your existing health record which includes:

The following checked items will be generated/collected during the course of this study:
☐ History and physical examinations
Reports: ☐ Laboratory ☐ Surgical ☐ Discharge ☐ Progress
☐ Photographs, videos, digital or other images
☐ Diagnostics images/X-ray/MRI/CT
☐ Bioelectric Output (e.g., EEG, EKG)
☐ Questionnaires, interview results, focus group survey, psychology survey, behavioral tests (e.g., memory and attention)
☐ Tissue and/or blood specimens
☐ Other:

Purpose

☐ Learn more about the disability/disease being studied.
☐ Facilitate treatment, payment, and operations related to the study.
☐ Comply with federal or other government agency regulations.
☐ Teaching or instructional.

☐ Other:

If the information to be used or disclosed contains any of the types of records or information listed below, additional laws relating to use and disclosure of the information may apply. You understand and agree that this information will be used and disclosed only if you place your initials in the applicable space.

___ Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection information.
___ Drug/alcohol diagnosis, treatment, or referral information.
___ Mental or behavioral health or psychiatric care.
___ Genetic testing information.

You will receive a copy of this authorization form after it has been signed.

Printed Name of PI

___________________________________ ___________________

Signature Date

____

Print Name of Person/Guardian Giving Consent

___________________________________ ___________________

Signature of Person/Guardian Giving Consent Date