**TITLE OF STUDY: (Insert Title)**

**Principal Investigator: (PI’s name)**

**PERMISSION (Authorization) TO USE OR SHARE HEALTH INFORMATION THAT IDENTIFIES YOU FOR A RESEARCH STUDY**

The next few paragraphs tell you about how investigators want to use and share identifiable health information from your medical record in this research. Your information will only be used as described here or as allowed or required by law. If you sign this consent form, you agree to let the investigators use your identifiable health information in the research and share it with others as described below. Ask questions if there is something you do not understand.

**What Is The Purpose Of The Research And How Will My Information Be Used?**

You are being invited to take part in this research study which is described at the beginning of this form. The purpose of collecting and using your health information for this study is to help investigators answer the questions that are being asked in the research.

**What Information About Me Will Be Used?**

* All information in your medical record
* Hospital discharge summaries
* Radiology records or images (MRI, CT, PET scans)
* Medical history or treatment
* Medications
* Consultations
* Laboratory/diagnostic tests or imaging
* EKG and/or EEG reports
* Pathology reports, specimen(s) or slide(s)
* Operative reports (about a surgery)
* Dental records
* Emergency Medicine reports

**Who May Use, Share or Receive My Information?**

The research team may use or share your information collected or created for this study with the following people and institutions:

* Rutgers University Investigators Involved In The Study
* The Rutgers University Institutional Review Board and Compliance Boards
* The Office for Human Research Protections in the U.S. Dept. of Health and Human Services
* Hospital Personnel as Necessary For Clinical Care: (list only hospital(s) that apply)
	+ University Hospital
	+ Robert Wood Johnson University Hospital
* Non-Rutgers Investigators On the Study Team: (Insert the affiliation and location of investigators at other institutions or organizations)
* The Food and Drug Administration (FDA)
* Representatives of the National Cancer Institute (NCI)

**List every other class of persons or organizations not affiliated with Rutgers University** towhom the subject’s information might be disclosed (for example, a sponsor of the research, a data safety monitoring board, researchers at other institutions, outside data analysis companies, the National Institutes of Health, etc.)

Those persons or organizations that receive your information may not be required by Federal privacy laws to protect it and may share your information with others without your permission, if permitted by the laws governing them.

**Will I Be Able To Review My Research Record While The Research Is Ongoing?**

No. We are not able to share information in the research records with you until the study is over. To ask for this information, please contact the Principal Investigator, the person in charge of this research study.

**Do I Have To Give My Permission?**

No. You do not have to permit use of your information. But, if you do not give permission, you cannot take part in this study. (Saying no does not stop you from getting medical care or other benefits you are eligible for outside of this study.)

**If I Say Yes Now, Can I Change My Mind And Take Away My Permission Later?**

Yes. You may change your mind and not allow the continued use of your information (and to stop taking part in the study) at any time. If you take away permission, your information will no longer be used or shared in the study, but we will not be able to take back information that has already been used or shared with others. If you say yes now but change your mind later for use of your information in the research, you must write to the researcher and tell them of your decision:

(PI’s name)

195 Little Albany Street

New Brunswick, NJ 08903

**How Long Will My Permission Last?**

There is no set date when your permission will end. Your health information may be studied for many years.

**HIPAA Permission (Authorization)**

**Subject Permission:**

I have read this entire HIPAA form, or it has been read to me, and I believe that I understand what has been discussed. I permit the investigators to use the information in my medical record for the research. I agree to take part in this study.

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

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

**Signature of Investigator/Individual Obtaining Permission:**

I have explained and discussed all of the important details about our request to use information stored in the individual’s medical record for the research.

Investigator/Person Obtaining Permission (print name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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