**HIPAA AUTHORIZATION**

INSTRUCTIONS: For studies involving the use of HIPAA protected health information (PHI) stored in medical records, add the following HIPAA Authorization (Permission) to the consent document [insert the authorization after Consent Section ‘Who can I contact if I have questions?’ but before the signature block. Delete all instructional text (highlighted in blue) before embedding in the consent document.

**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 invited to participate in this research study 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 being asked in the research.

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

(Tailor the list to reflect only what your study will collect. Collect only what is needed to satisfy study aims and is consistent with what is outlined in the protocol to be collected.)

* 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
* Psychological testing, surveys or questionnaires
* Pathology reports, specimen(s) or slide(s)
* Operative reports (about a surgery)
* Dental records
* Emergency Medicine reports
* Other (specify)

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

**(Required Text)**

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

**(Additional Items as Applicable)**

* Hospital Personnel as Necessary for Clinical Care (list only hospitals that apply):
	+ University Hospital
	+ Robert Wood Johnson University Hospital
	+ Barnabas Health
* Non-Rutgers Investigators on the Study Team: (Insert the affiliation and location of investigators at other institutions or organizations)
* The Food and Drug Administration— (For studies involving drugs or biologics, etc.)
* **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 cannot share information in the research records with you until the study is over. To request this information, please get in touch with 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 the use of your information. But, if you do not give permission, you cannot participate 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: (insert the investigator’s name and address here).

**How Long Will My Permission Last?**

Your permission for the use and sharing of your health information will last until (List a specific date or event on which the subject’s permission for their health records will expire, e.g., “December 31, 2020” or “end of the research study”. If a subject’s permission will never end, or you don’t know an end-date, say so. Consider using the following sentence: “There is no set date when your permission will end. Your health information may be studied for many years.”