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

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

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

The next few paragraphs tell you about how investigators want to use and share identifiable health information from your child’s medical record in this research. Their 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 child’s 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 child’s information be used?**

Your child is invited to take part in this research study, which is described at the beginning of this form. The purpose of collecting and using their health information for this study is to help investigators answer the questions being asked in the research.

**What information about my child 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 child’s information?**

The research team may use or share your child’s 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
* 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 child’s information may not be required by Federal privacy laws to protect it. They may share your information with others without your permission if permitted by the laws governing them.

**Will I be able to review my child’s 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 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 child’s information. But, if you do not give permission, your child cannot take part in this study. (Saying no does not stop your child from getting medical care or other benefits s/he is 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 child’s information (and to stop taking part in the study) at any time. If you take away permission, your child’s 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 child’s 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 child’s health information may be studied for many years.

**HIPAA Permission (Authorization)**

**Parental Permission:**

I have read this entire HIPAA form, or it has been read to me, and I believe I understand what has been discussed. I permit the investigators to use the information in my child’s medical record for the research.

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

Parent/Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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

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