## Please read this HIPAA Authorization for Research template carefully. An authorization is distinct from a research consent, and includes the core elements and statements required by the HIPAA Privacy Rule (45 CFR 164.508). Instructions are in red text; these instructions within the [brackets] MUST—after you have entered therein the required text in black font as well as completed the tables below—BE DELETED in order for this form to be submitted to and approved by the IRB. Use the check boxes to indicate the types of health information that will be used or shared, the organizations that will use or share study participants’ health information, and the persons to or with whom study participants’ health information will be used or shared. If applicable and where indicated, add text as instructed. The Sections, elements and language in black text below must be retained; this form will be returned to you if any of these required content are deleted or missing.

## Title of research study: ***[insert title of research study here with RAMP IRB/protocol number, if applicable]***

## Researcher: ***[insert first and last name of Principal Investigator (PI) as it appears in the study protocol]***

## Faculty Advisor: [IF the PI is a student then insert Advisor First Last Name, credentials and FSU affiliation; otherwise state “none”]

## Why am I being invited to give this permission?

## We would like to get your permission to use and share health information that can identify you. We would like to use this information for the study listed above.

## Your health information is protected by law. This means that for this study, your health information may be used or shared if you agree. Your permission to use and share your health information is different from your agreement to take part in a study. This form explains how we will use and share your health information. It lists who can see and use your information. It explains what we will do to keep your health information private.

## Once we have your health information, it might no longer be protected by law. Your health information might be used or shared with others. You will get a copy of this form.

## Please read this form before you sign it. If you do not know what something means, you can ask us. Before you sign this, you can talk it over with someone you trust.

***What Health Information will be used or shared?***

If you give your permission and sign this form, the researcher and their study team will use or share health information that can identify you. For this study only the health information marked below will be used or shared: ***[Check one or more of the boxes below for health information for which use or disclosure you will seek study participants’ authorization. For “Other,” check the box and then provide a description of the specific other information to be used or disclosed that identifies the information in a specific and meaningful fashion; do not leave this description blank. Choose carefully since once the IRB approves and finalizes this authorization form, any of your subsequent changes to this form must first be reviewed and approved by the IRB through your submission of a study modification]***

|  |  |  |
| --- | --- | --- |
|  | Research record | Genetic test results and genetic information |
|  | Entire Medical Record | Dental records |
|  | Medical history, physical exams | Outpatient care records |
|  | Lab and other test results | Information about mental health exams or treatment |
|  | X-ray and imaging reports | Information about drug or alcohol use, diagnosis or treatment |
|  | Emergency and urgent care records | HIV/AIDS test results and information |
|  | Financial records | Other: |

You may not want some kinds of health information used or shared for this study. List below any kinds of health information that you do not want to use or share. If you list nothing here, we can use and share all of the health information checked above.

***What organizations’ health information about me will you use or share?***

The study team will ask only the organizations marked below to use or share the health information that they have about you: ***[Check one or more of the boxes below for those categories of organizations that you will ask to use or share study participants’ Protected Health Information (PHI). Then for EACH checked box, identify by name the entity, organization, agency, person(s) or class of persons, or provider(s) from which you will use or share participants’ PHI. For “Other,” check the box and provide the identification of the organization, agency, person(s), or class of persons or providers. Choose carefully since once the IRB approves and finalizes this authorization form, any of your subsequent changes to this form must first be reviewed and approved by the IRB through your submission of a study modification]***

|  |  |  |
| --- | --- | --- |
|  | Florida State University: | Federal agency or department: |
|  | Florida State agency or department: | Tallahassee-area health care provider(s): |
|  | Florida health care providers outside of Tallahassee: | Other: |

***Who will receive or be able to see or use my health information?***

The persons or offices listed below may receive or be able to see or use your health information: ***[Check one or more of the boxes below to indicate those persons or offices to or with whom you may use or share study participants’ Protected Health Information (PHI). For “Other” organizations, check the box and provide the name or other identification of the specific organization, person(s), or class of persons to or with whom study participants’ PHI will be used or disclosed. Choose carefully since once the IRB approves and finalizes this authorization form, any of your subsequent changes to this form must first be reviewed and approved by the IRB through your submission of a study modification]***

|  |  |  |
| --- | --- | --- |
|  | The Researcher and other persons who are part of the research team for the study, listed above | Persons at other institutions who are responsible for protecting study participants such as you, or for monitoring the study’s safety |
|  | Health care staff who provide services to you or use your health information in connection with the study | Other: |

Persons at Florida State University who are responsible for protecting study participants such as you, or for monitoring the study’s safety, such as the Institutional Review Board or the Office for Human Subjects Protection, may also receive or be able to see or use your health information. So too may other persons who may be required or permitted by law to review the quality and safety of the study, such as the Food and Drug Administration, the Office of Human Research Protections, or the sponsor of the research study.

A copy of this form may be placed in your medical record. Also, information about medications, tests and other procedures that are done as part of the research study may also be placed in your medical record if related and necessary for your health care. This information may be seen by other health care providers who have access to your medical record.

***Who else can use and share this information?***  
  
Anyone checked above may involve other persons to help them with this study. They may use and share information about you to do this research. If you have questions about who they are, you can ask us.

Once any information leaves Florida State University, we cannot promise that others will keep it private. If others share your health information, the information may no longer be protected by federal privacy laws.

***Am I required to sign this document?***

**No, you do not need to sign this form. Your permission is voluntary.** You are **not** required to sign this form and you may refuse to do so. Any services or care that you are entitled to receive will not change if you decide not to sign this form. However, if you do not sign this form, you will not be able to participate in this study. You should take as much time as you need to make your decision about giving permission to use or share your identifiable health information for this study. Please ask any questions you have about this form.

***Your Rights***

You can revoke (end your permission) this form at any time. This means you can tell us to stop using and sharing your health information. Beginning on the date your permission ends, no new health information that identifies you will be used. Any health information that was shared before you withdrew your permission will continue to be used. To revoke this form, you must tell us in writing. Please write to:

Principal Investigator: [insert first and last name of PI as it appears above]

Title of research study: [insert title of research study as it appears above]

Mailing address: ***[Insert complete FSU mailing address]***

Expiration Date. Unless you revoke this form in writing, this form will: ***[Insert a statement to the effect that this form: will expire on (and add a Month Day, Year); will expire on a specific expiration event (e.g., the study is closed or we have received your health information); will not expire or similar language]***

By signing below, I agree to let researchers use and share my health information as explained to me on this form. I will be given a copy of this form after I have signed it.

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Signature of Study Participant or Personal Representative

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Printed Name of Study Participant or Personal Representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

Explain authority of Personal Representative to act for the Study Participant:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_