UNIVERSITY OF OKLAHOMA – NORMAN CAMPUS

INSTITUTIONAL REVIEW BOARD

AUTHORIZATION TO USE or DISCLOSE

PROTECTED HEALTH INFORMATION FOR RESEARCH

*An additional Informed Consent Document*

*For Research Participation may also be required.*

Title for Research project:

Principal Investigator:      

IRB Number:

Address:

Phone Number:

If you decide to join this research project, University of Oklahoma (OU) researchers may use or share (disclose) information about you that is considered to be protected health information for their research. Protected health information (PHI) is information about past, present, and future medical treatment or condition that is identifiable to you. It will be called PHI in this Authorization.

**PHI To be Used or Shared**. Federal law requires that researchers get your permission (authorization) to use or share your PHI. If you give permission, the researches may use or share with the people identified in this Authorization any PHI related to this research from your medical records and from any test results. Information used or shared may include all information relating to any tests, procedures, surveys, or interviews as outlined in the consent form; medical records and charts; name, address, telephone number, date of birth, race and government-issued identification numbers.

**Purposes for Using or Sharing PHI**. If you give permission, the researchers may use your PHI to **(describe each research purpose fully).**

**Other Use and Sharing of PHI**. If you give permission, the researchers may also use your PHI to develop new procedures or commercial products. They may share your PHI with the other researchers, the research sponsor, and its agents, the OU Institutional Review Board, auditors and inspectors who check the research, and government agencies such as the Department of Health and Human Services (HHS). The researchers may also share your PHI with **(list all such persons or groups, including collaborating researchers or teams at other institutions as well as family members or other groups of individuals)**.

**Confidentiality**. Although the researcher may report their findings in scientific journals or meetings, they will not identify you in their reports. The researchers will try to keep your information confidential, but confidentiality is not guaranteed. The law does not require everyone receiving the information based on this authorization to keep it confidential, so they could release it to others, and federal law may no longer protect it.

**YOU UNDERSTAND THAT YOUR PROTECTED HEALTH INFORMATION MAY INCLUDE INFORMATION REGARDING A COMMUNICABLE OR NONCOMMUNICABLE DISEASE.**

**Voluntary Choice**. The choice to give OU researchers permission to use or share your PHI for their research is voluntary. It is completely up to you. No one can force you to give permission. However, you must give permission for OU researchers to use or share your private health information if you want to participate in the research and if you revoke your authorization, you can no longer participate in this study.

Refusing to give permission will not affect your ability to get routine treatment or health care from OU.

**Revoking Permission**. If you give OU researchers permission to use or share your private information, you have a right to revoke your permission whenever you want. However, revoking your permission will not apply to information that the researchers have already used, relied on, or shared.

**End of Permission**. Unless you revoke it, permission for OU researchers to use or share your PHI for their research will **(insert as appropriate: “end on \_\_\_” specify the end date).** You may revoke your permission at any time by writing to:

Privacy Official or Privacy Board

University of Oklahoma University of Oklahoma

PO Box 26901 1816 W. Lindsey, Suite 150

Oklahoma City, OK 73190 Norman, OK 73069

(405) 271-2511 (405) 325-8110

If you have any questions, please call.

**Access to Information.** You have the right to access the medical information that has been collected about you as a part of this research study. However, you may not have access to this medical information until the entire research study is completely finished. You consent to this temporary restriction.

**Giving Permission**. By signing this form, you give OU and OU’s researchers led by **(insert name of Principal Investigator),** permission to share your PHI for the research project called **(insert title of research project as listed at the top of this form).**

**Participant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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Signature of Participant Date

Or Parent if Participant is a Minor

***Or***

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Signature of Legal Representative\*\* Date

\*\*If signed by a Legal Representative of the Participant, provide a description of the relationship to the Participant and the Authority to Act as Legal Representative:

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

OU may ask you to produce evidence of your relationship.

***A signed copy of this form must be given to the Participant or the Legal Representative at the time this signed form is provided to the researcher or his representative.***