**Weill Cornell Medical College**

**HIPAA AUTHORIZATION TO USE or DISCLOSE PROTECTED HEALTH INFORMATION FOR RESEARCH**

|  |  |
| --- | --- |
| **Project Title:** |  |
|  |  |
| **Research Project/Protocol #:** |  |
| **Principal Investigator:** |  |
| **Subject Name:** |  |
| **MRN:** |  |

**What is the Purpose of this form?**

Government rules require that researchers get your permission (authorization) to use or share your protected health information. To do research, we will need to collect, use, and share (disclose), your protected health information. If you decide to join this study, researchers need your permission to use your protected health information. By signing this form, you agree that the study team may use or share your protected health information for this study. The study team will use and protect your health information as described in the Consent Form.

**Voluntary Choice**

You do not have to sign this HIPAA Authorization form to give the study team permission to collect, use or share your protected health information. It is completely up to you. If you do not sign this HIPAA Authorization, you may not join this study, because the study team will not be able to collect, use or share the information they need to do their research. If you do not sign this Authorization, you will continue to receive your usual treatment or health care from this institution.

**Protected Health Information To Be Used or Shared**

Your protected health information may be shared with authorized public health or government officials for public health activities when required or authorized by law. The study team could also use your protected health information to develop new procedures or commercial products. If you give permission, the study team could use or share any protected health information for this study. This includes **all information in your medical and research record(s), including and not limited to your full medical and surgical histories and all laboratory results.**

**Specific Use Permission**

The researchers may collect the below information from your medical record. The following information will only be released if you give your specific permission by putting your initials on the line(s).

I agree to the release of information pertaining to drug and alcohol abuse, diagnosis or treatment. \_\_\_\_\_\_\_\_\_ (initials)

I agree to the release of HIV/AIDS testing information.\_\_\_\_\_\_\_\_ (initials)

I agree to the release of genetic testing information.\_\_\_\_\_\_\_ (initials)

I agree to the release of information pertaining to mental health diagnosis or treatment.\_\_\_\_\_\_ (initials)

Protecting your health information is important to us. If your protected health information is shared by your health care providers or the study team to others, federal and state confidentiality laws may no longer protect it. If you agree to participate in this study, your protected health information may be shared with these people.

* Weill Cornell Medical College
* Local Institutional Review Board (IRB)
* NCI Central Institutional Review Board (NCI CIRB)
	+ If you are in a cancer study that receives federal funding, the National Cancer Institute (NCI) requires that we report identifiable information (for example: zip code) about you to track which groups of people participate in research. Please contact the NCI if you have questions about how this information is used
* Inspectors who check the research
* Government agencies, such as the Office of Human Research Protection (OHRP)
* Department of Health and Human Services and National Institutes of Health
* Food and Drug Administration (FDA) and/or their representatives
* The Sponsor and/or their representatives
* Research staff, investigators at other sites
* A safety monitoring committee such as a Data Safety Monitoring Board (DSMB)

**Access to Research Records**

During the course of this study**, you may not have access** to see or copy parts of your protected health information that include research information (for example correlative studies results) described in this authorization. This is an institution policy that prevents knowledge of study results from affecting the reliability of the study. By signing this form, you are agree to this limitation of access to your protected health information.

**What If You Change Your Mind?**

**Canceling Permission:**

You may cancel your permission at any time. If you give the researchers permission to use or share your protected health information, you have the right to cancel your permission at any time. However, canceling your permission will not apply to information that the researchers have already used or shared.

If you wish to cancel your permission, you may do so at any time by writing to:

Weill Cornell Medical College

Privacy Office

1300 York Avenue, Box 303

New York, NY, 10065

Email: privacy@med.cornell.edu

If you have questions about this and would like to discuss, call (646) 962-6930.

**End of Permission**

Permission for researchers to use or share your protected health information for their research will never end, unless your cancel your permission.

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**Signatures**

I give permission for the research team to use collect, use, or share my protected health information for their research.

|  |  |  |
| --- | --- | --- |
| **Signature** of Patient | **Printed Name** of Patient | Date |
| **Signature** of Patient Legal Representative | **Printed Name** of Patient Legal Representative | Date |
| **Signature** of Interpreter | **Printed Name** of Interpreter | Date |
| **Signature** of Person Present During Oral Presentation | **Printed Name** of Person Present During Oral Presentation | Date |