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|  | FORM: HIPAA Authorization for the Use of Patient Information for Research |

FHIRB #:       Protocol number:

Title of Research Study:

If you consent to participate in Research, we must get your permission to share patient information about you/your child for use in Research. This form describes what we will do if you give your permission.

By signing this form, you permit your/your child’s patient information to be shared with Fred Hutchinson Cancer Center, its staff, and others who work with them. In this form, the term for all these people is “Researchers.” Their individual names will appear on the Research Consent form that you sign for this Study.

Federal and state laws require that you give your permission for the Researchers to see and use patient information. A federal law known as the Health Insurance Portability and Accountability Act (also called “HIPAA”) protects the confidentiality of patient information created and used by your health care providers. Once patient information is disclosed to the Researchers, it will no longer be protected by HIPAA and could be re-disclosed. However, other laws do apply to the Researchers that require them to protect the confidentiality of your/your child’s information.

The Researchers will use the patient information only for the purposes named in this form.

**1.** **The patient information to be obtained and used includes:**

* All patient information in your/your child’s medical records needed by the Researchers for the Study. It also includes information in your/your child’s records that can identify you/your child. For example, it can include your/your child’s name, address, phone number, birth date, and medical record number.
* The specific patient information that will be obtained and used for the Research is described below: [*Delete information that is not applicable.* ***BY LAW,*** *the information must be limited to the minimum necessary information needed to accomplish the purpose of the Research. If you do not need access to the sensitive information categories of health information described in Section Five, do not list them here and do not include the explicit permission statement described in Section Five*]*.*
* Hospital discharge summary
* Radiology records
* Medical history/treatment
* Consultation
* Radiology films (like X-rays or CT scans)
* Laboratory/diagnostic test
* EKG report
* EEG report
* Psychological testing
* Pathology reports
* Operative report (about an operation)
* Pathology specimen(s) and/or slide(s)
* Diagnostic imaging report
* Dental records
* [*specify other here*]

**2. What the Researchers may do with patient information.**

The Researchers will use your/your child’s patient information only in the ways described in the Research Consent form that you sign and as described here. They may also share your/your child’s patient information with certain people and groups. These may include:

* The sponsor of the Study. A sponsor provides support for research studies. The sponsor for this Study is identified in the Research Consent form that you sign. The sponsor reviews the Study. By law, Researchers share some information with the sponsor.
* Government agencies, review boards, and others who watch over the safety, effectiveness and conduct of the research
* Others, if the law requires.

The Research Consent form you sign for this Study will describe who will have access to your/your child’s patient information. It also describes how your/your child’s information will be protected. By law, the Researchers are required to protect the confidentiality of your/your child’s information. You/your child may ask questions about what the Researchers will do with your/your child’s information and how they will protect it.

**3. How long the permission will last?**

The permission for the Researchers to obtain and use your/your child’s patient information will end when the Researchers complete the research study AND any review of the research study is completed. OR

 The permission for the Researchers to obtain and use your/your child’s patient information will end on [*insert date*] or [*insert description of event or other circumstances. Examples: one year after death; one year after you/your child reaches the age of 50.*]

**4. Canceling your permission.**

You may change your mind and take back your permission anytime. To take back your permission, write to: [insert name and contact information here]. If you do this, you/your child may no longer be allowed to be in the Study. The Researchers may still keep and use any patient information they already have. But they can’t obtain more patient information about you/your child for the Research unless it is required by a federal agency that reviews the Research.

**5. Giving permission**

You give your permission for the use of your/your child’s patient information by signing this form.

[*Insert the following if applicable. For example, if ALL patient information is required or if patient information requires access to the categories of patient information listed below*]

Federal and state laws require that you provide specific permission for certain types of information to be shared with the researchers. These types of information include any diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and alcohol abuse, mental illness or psychiatric conditions. Please note that federal law prevents the use of this type of information to criminally investigate or prosecute alcohol or drug abuse patients.

 **I give my specific authorization for this information to be released: Yes \_\_\_ No \_\_\_\_**

**Signature**

I agree to let my/my child’s doctors and other health care providers disclose patient information that identifies me/my child with the Researchers.

My/my child’s doctors and other health care providers could include: *(Note: List only those that apply and be sure to delete those that do not apply.)*

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| --- | --- |
| * UW Medicine
 | * Seattle Children’s Hospital
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| * Fred Hutchinson Cancer Center
 | * Swedish Medical Center
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| * Virginia Mason Medical Center
 | * Veterans Affairs Puget Sound Health Care System
 |
| * Bastyr University
 | * Group Health Cooperative facilities
 |
| * [List others known] →
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Signature of participant or participant’s Legal Date

Representative

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Printed name of participant or participant’s Representative’s relationship

Legal Representative to participant