IRB Protocol Number:	**Principal Investigator:**
Departmental Study Code:	

HIPAA Research Authorization Template – Form B
AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I agree to permit the ☐ *University of Miami* ☐ *Jackson Health System* ☐ *both*, and any of my doctors or other health care providers (together "Providers"), Principal Investigator and [*his /her/their/its*] collaborators and staff (together "Researchers"), to obtain, use and disclose health information about me as described below. Authorized staff not involved in the study may be aware that I am participating in a research study and may have access to my information. If the study is related to my medical care, any study-related information may be placed in my permanent hospital, clinic or physician's office records.

1. The health information that may be used and disclosed may include:

☐ All information collected during the research and procedures described in the Informed consent Form for the Research as described in the accompanying study specific Informed Consent Form
("the Research"): and

☐ Health information in my medical records that is relevant to the Research, includes my past medical history including medical information from my primary care physician and other medical information relating to my participation in the study; and

[The following checked boxes must be separately initialed by you in order to permit access to these records]

_____ ☐ HIV / AIDS status.
HIV-related information, which includes any information indicating that I have had an HIV-related test, or have HIV infection, HIV-related illness or AIDS, or any information which could indicate that I have been potentially exposed to HIV.

_____ ☐ Sexually transmitted diseases (STD's).

_____ ☐ Mental health treatment records governed under state law (including mental health records relating to involuntary or voluntary mental health treatment).
Mental health records may include substance abuse information .

_____ ☐ Substance abuse (drug and alcohol) treatment records.
Substance abuse information may be part of the mental health records.

_____ ☐ Sexual assault information.

2. The Providers may disclose health information in my medical records to:

- the Researchers;
- representatives of government agencies, any applicable Cooperative Groups, review boards, and other persons who watch over the safety, effectiveness, and conduct of research; and
- the sponsor of the Research, ,

and its agents, monitors and contractors (together "Sponsor").

3. The Researchers may use and share my health information:

- among themselves, with the Sponsor, with any applicable Cooperative Groups, health care facilities, research sites, independent data and safety monitoring boards, study monitors and with other participating Researchers (internal and/or external) to conduct the Research;
- Federal and State agencies that have oversight of the study or whom access is required under the law. These may include FDA, OHRP, NIH and Florida DOH; and
- as permitted by the Informed Consent Form.

4. **The Sponsor and any applicable Cooperative Groups may use and share my health information** for purposes of the Research, data safety and monitoring and as permitted by the consent form.

   Contract Research organization(s): [ ]

5. **Once my health information has been disclosed to a third party,** federal privacy laws may no longer protect it from further disclosure.
6. **I hereby authorize the Sponsor to observe any medical procedures I undergo as part of the Research.**
7. **Please note that:**
   You do not have to sign this Authorization, but if you do not, you may not participate in the Research. If you do not sign this authorization, your right to other medical treatment will not be affected.

   You may change your mind and revoke (take back) this Authorization at any time and for any reason. To revoke this Authorization, you must write to either of the following:

   ***Research Study Personnel Name:**

   Address:

   Tel. No.:

   Human Subjects Research Office

   Address: 1400 NW 10th AVE, Suite 1200A Miami, FL 33136

   Tel. No.: (305) 243-3195

   However, if you revoke this Authorization, you will not be allowed to continue taking part in the Research. Also, even if you revoke this Authorization, the Providers, Researchers, any applicable Cooperative Groups and the Sponsor may continue to use and disclose the information they have already collected to protect the integrity of the research or as permitted by the Informed Consent Form.

   While the Research is in progress, you may not be allowed to see your health information that is created or collected by the ☐ *University of Miami* ☐ *Jackson Health System* ☐ *both*, in the course of the Research. After the Research is finished, however, you may see this information as described in the ☐ *University of Miami* ☐ *Jackson Health System* ☐ *both*, Notice of Privacy Practices.

   ***Study personnel must send copies of participant revocations to:**
   Office of HIPAA Privacy and Security AND the Human Subjects Research Office.

8. **This Authorization does not have an expiration (ending) date.** There is no set date at which your information will be destroyed or no longer used. This is because the information used and created for the study may be analyzed for many years, and it is not possible to know when this will be complete.
9. **You will be given a copy of this Authorization after you have signed it.**

_____ _____

Signature of participant or participant's legal representative Date

_____

Printed name of legal representative (if applicable)

_____

Printed name of participant

_____

Representative's relationship to participant

Study personnel must send copy with signature to the Office of HIPAA Privacy and Security
For questions, contact the Human Subjects Research Office at 305-243-3195.
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