Office of Research Services

Principal Investigator: _____ IRB #: _____

Project Title: _____

Authorization to Use and Disclose Your Health Information for a Research Study

Information about this authorization form:

- Signing this authorization is voluntary.
- You may refuse to sign this authorization.
- If you do not sign this authorization, your health care and your relationship with your health care provider and the will not be affected.
- If you do not sign this authorization, you will not be able to take part in this research study.
- You must read this form before you sign it.
- Please ask us about anything you would like to understand better before you make your decision.
- This authorization does not expire unless you cancel it in writing.
- You will receive a copy of this authorization after it is signed.
- To maintain the integrity of the research, you may be unable to access copies of your medical records until the study is complete.

Confidentiality and privacy:

- Your medical records are confidential.
- The researchers and entities listed in this authorization agree to protect your health information by using and sharing it only as permitted in this authorization and for other purposes permitted by state and federal law.
- The results of this research may be published for scientific purposes or presented to scientific groups; however, you will not be identified.
- Once your health information is released it may not be protected by the privacy laws and might be shared with others. If you have questions, ask a member of the research team.

Your protected health information includes:

- Medical records that identify you.
- Information collected or created during this research study.
- This authorization form.
- The informed consent form you signed.
- Medical records from treatment you received prior to giving consent to participate in this clinical study may be used to verify your medical history and eligibility for this study.
- Drug and alcohol abuse records are specifically protected by federal regulations and by signing this authorization you are allowing the release of any drug and/or alcohol information to the agency or person specified in this authorization.
- The information released may include medical records related to infection with HIV (Human Immunodeficiency Virus).

What protected health information will be used or shared about you in this study?

☐ All geographical subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code, if according to the current publicly available data from the Bureau of the Census: (1) The geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and (2) The initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000.

☐ Admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older

☐ Phone Numbers ☐ Biometric identifiers, including finger and voice prints ☐ Device Identifiers and Serial Numbers

☐ Internet Protocol (IP) Address Numbers ☐ Web Universal Resource Locators (URLs)

☐ Vehicle Identifiers and Serial Numbers, including License Plate Numbers ☐ Medical Record Numbers

☐ Health Plan Beneficiary Numbers ☐ Account Numbers ☐ Certificate/License Numbers

☐ Social Security Numbers ☐ Electronic Mail Addresses ☐ Fax Numbers ☐ Names

☐ Full face photographic images and any comparable images

☐ Any other unique identifying number, characteristic, or code (note this does not mean the unique code assigned by the investigator to code the data)

Who may use or share your information in this research study?

1. The research team, including the Principal Investigator, study coordinator, and all other research staff.
2. All health care staff that treat and serve you as a part of this research.
4. The Sponsor(s) of this study: _____

   The Contract Research Organization: _____

   The Central Laboratory(ies): _____
5. Business Associates involved in this study: _____
6. Any agency of the federal, state, or local government that regulates this research. This includes the Food and Drug Administration (FDA) and the Department of Health and Human Services (DHHS).
7. Members of the UMKC review board(s) that oversee this research, including but not limited to the Institutional Review Board (IRB) and Privacy Board.
8. Governmental regulatory agencies in other countries where the study information may be reviewed.
9. Other: _____

Canceling this authorization:

- You must do so in writing; e-mail and verbal cancellations are not accepted.
- You will stop taking part in this research study, and we will stop collecting information about you for this research study.
- Information collected before you cancelled your authorization may be used or shared or may have already been used or shared during the study.
- If there is a medical reason to do so, our staff will follow up with you after you leave the study and may continue to collect information about that medical reason.

To cancel your authorization please write to:

University of Missouri - Kansas City Institutional Review Board
Attn: Privacy Officer
5319 Rockhill Road
Kansas City, MO 64110

Any questions or concerns regarding authorization or this form may be directed to the UMKC Privacy Officer at 816-235-5927.

I authorize those referenced above under "Who may use or share your information in this research study" to use and share my protected health information (PHI) for the purpose of research. This authorization includes medical and scientific use in this research study.

_____ _____

Signature of Subject Date

_____ _____

Signature of Legally Responsible Party (if applicable) Date

_____ _____

Signature of Person Obtaining Authorization Date