**DO NOT SUBMIT THIS PAGE TO RCS OR THE IRB**

**THIS PAGE IS INFORMATIONAL AND INSTRUCTIONAL ONLY AND**

**NOT FOR USE WITH PARTICIPANTS IN RESEARCH**

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| **Purpose:** A Privacy Rule Authorization is an individual’s signed permission to allow a covered entity to use or disclose the individual’s protected health information (PHI) that is described in the Authorization for the purpose(s) and to the recipient(s) stated in the Authorization. In contrast, an informed consent document is an individual’s agreement to participate in the research study and includes a description of the study, anticipated risks and/or benefits, and how the confidentiality of records will be protected, among other things. An Authorization can be combined with an informed consent document or other permission to participate in research. |

**Instructions:**

* Save this form to your computer before proceeding.
* The text in yellow-highlighted brackets [] provides instructions and indicates information that must be inserted.
* The text in turquoise-highlighted brackets [] provides instructions or information.
* When you have finished providing all of the requested information and/or information.
  + Delete the instructions that are turquoise-highlighted in the brackets, and delete the brackets.
  + Remove the yellow highlighting (by changing it to white).
* This form does not need to be printed in color.

**Authorization to Use or Disclose (Release) Health Information that Identifies You for a Research Study**

If you sign this document, you give permission to [Enter name or other identification of specific health care provider(s) or description of classes of persons, e.g., all doctors, all health care providers] at [Enter name of covered entity or entities] to use or disclose (release) your health information that identifies you for the research study described here:

[Provide a brief description of the research study, such as the title and purpose of the research.]

The health information that we may use or disclose (release) for this research includes:

[Provide a description of information to be used or disclosed for the research project. This may include, for example, all information in a medical record, results of physical examinations, medical history, lab tests, or certain health information indicating or relating to a particular condition.]

The health information listed above may be used by and/or disclosed (released) to: [Name or class of persons involved in the research; i.e., researchers and their staff \*]

The “covered components” of the University of Oregon are required by law to protect your health information. By signing this document, you authorize the covered components of the University of Oregon to use and/or disclose (release) your health information for this research. Those persons who receive your health information may not be required by Federal privacy laws (such as the Privacy Rule) to protect it and may share your information with others without your permission, if permitted by laws governing them.

Please note that [include the appropriate statement from options below]:

[**OPTION 1**.*Include the following statement when the research involves treatment and is conducted by the covered entity or when the covered entity provides health care solely for the purpose of creating protected health information to disclose to a researcher, otherwise delete it.*]

You do not have to sign this Authorization, but if you do not, you may not receive research-related treatment.

[**OPTION 2.** *Include the following statement when the research does not involve research-related treatment by the covered entity or when the covered entity is not providing health care solely for the purpose of creating protected health information to disclose to a researcher, otherwise delete it*.]

The covered components of the University of Oregon may not condition (withhold or refuse) treating you on whether you sign this Authorization.

Please note that [include the appropriate statement from options below]:

[**OPTION 1**. *Include the following statement where the research study is conducted by an entity other than the covered entity, otherwise delete it.*]

You may change your mind and revoke (take back) this Authorization at any time, except to the extent that the covered components of the University of Oregon have already acted based on this Authorization. To revoke this Authorization, you must write to: [name of the covered entity(ies) and contact information].

[**OPTION 2**. *Include the following statement where the research study is conducted by the covered entity, otherwise delete it.*]

You may change your mind and revoke (take back) this Authorization at any time. Even if you revoke this Authorization, [name or class of persons at the covered entity involved in the research] may still use or disclose health information they already have obtained about you as necessary to maintain the integrity or reliability of the current research. To revoke this Authorization, you must write to: [name of the covered entity(ies) and contact information].

This Authorization does not have an expiration date. [or as appropriate, insert expiration date or event, such as “end of the research study.”]

[The research participant should sign and date this form. If the research participant is a minor, the legally authorized representative should sign and date this form.]

Signature of participant or participant’s personal representative Date

Printed name of participant or participant’s personal representative Date

[If applicable, a description of the personal representative’s authority to sign for the participant.]

**[OPTIONAL ELEMENTS:**

Examples of optional elements that may be relevant to the recipient of the protected health information:

* Your health information will be used or disclosed when required by law.
* Your health information may be shared with a public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, and conducting public health surveillance, investigations, or interventions.
* No publication or public presentation about the research described above will reveal your identity without another authorization from you.
* If all information that does or can identify you is removed from your health information, the remaining information will no longer be subject to this authorization and may be used or disclosed for other purposes.
* **When the research for which the use or disclosure is made involves treatment and is conducted by a covered entity:** To maintain the integrity of this research study, you generally will not have access to your personal health information related to this research until the study is complete. At the conclusion of the research and at your request, you generally will have access to your health information that the covered components of the University of Oregon maintain in a designated record set, which means a set of data that includes medical information or billing records used in whole or in part by your doctors or other health care providers at the covered components of the University of Oregon to make decisions about individuals. Access to your health information in a designated record set is described in the Notice of Privacy Practices provided to you by the covered components of the University of Oregon. If it is necessary for your care, your health information will be provided to you or your physician.
* If you revoke this Authorization, you may no longer be allowed to participate in the research described in this Authorization.]