**HIPAA AUTHORIZATION**

**FOR USE OF PROTECTED HEALTH INFORMATION IN RESEARCH**

## 1. I HEREBY AUTHORIZE: Meriter Hospital, Inc., 202 South Park Street, Madison, Wisconsin 53715

**2. TO RELEASE INFORMATION TO:**

*Click here. Enter the* ***Name and Address of Principal Investigator***

Name of Researcher (Principal Investigator) Street Address City State Zip Code

1. **INFORMATION REGARDING:**

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**Print First and Last Name** **Date of Birth**

**4. PURPOSE OF DISCLOSURE:**

Your medical information (checked in the list below) is being disclosed for the purposes of conducting and reporting the results of the research titled Click here to enter the ***Title*** of the study. If you are banking identified health information or specimens for future research, describe the type of future research the subjects’ specimens and/or information may be used for.

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**5. TYPE OF INFORMATION DISCLOSED:** (Check all that apply)

Discharge summary Cardiac testing Emergency Room Record

History and Physical Consultations  Therapy Notes (OT, PT, Speech)

X-ray Lab Anesthesia Records Operative/Pathology Reports

Other (Specify) Click and ***enter text.***

**6. EXPIRATION:** End of research study

**7. THE RESEARCHER:**

1. May use and share my protected health information to conduct research.
2. May disclose my protected health information which may include the research product to the Sponsor of the research or others as listed below:

Click and enter ***Research Sponsor Name and address*** if applicable.

Name of Research Sponsor (if none type “none”) Street Address City State Zip Code

Enter ***another party that subject information will be disclosed to.***

Other Name (if none write in “none”) Street Address City State Zip Code

1. Will obtain my authorization to release my protected health information to anyone other than those individuals stated above.
2. Whenever possible, will keep your health information confidential. Federal privacy laws (e.g., HIPAA) may not apply, however, to some people outside of Meriter Hospital, Inc. who are not health care providers or health care insurers who can share your health information without your permission. If you signed a consent form to take part in this research, more information about confidentiality protections may be found there.
3. May disclose my protected health information to representatives of government agencies including the US FDA where required by law.
4. Enter the ***researcher’s name.*** Enter the ***sponsor’s name*** (if applicable) agree to protect my health information by using and disclosing it as permitted by me in this authorization. Furthermore, no publication about the research will reveal my identity without my express written permission. These limitations continue even if I revoke (take back) this authorization.
5. May place a copy of this authorization in your medical record after it is signed. This means there will be a record of you participating in this study in your medical record.

**YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATON:**

**Right to Refuse to Sign This Authorization -** I do not have to sign this form. My health care providers must continue to provide me with health care services even if I refuse to sign this Authorization form. Signing this form does not affect my health benefits or eligibility for benefits. If I do not sign this form, I cannot participate in the research.

**Right to Receive Copy of This Authorization -** If I agree to sign this authorization, I must be provided with a signed copy of this form.

**Right to Revoke This Authorization -** I may revoke my authorization in writing at any time. To revoke this authorization, I must write to Researcher named above. If I revoke this authorization, I may no longer be allowed to participate in the research. Furthermore, even if I revoke this authorization, the researchers may still use and disclose health information they already have obtained as needed to maintain the reliability of the research.

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**SIGNATURE OF SUBJECT** **DATE SIGNED**

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#### SIGNATURE OF SUBJECT’S LEGAL REPRESENTATIVE/RELATIONSHIP (if applicable) DATE SIGNED

#### *Mail or Fax (417-6016) the signed authorization form to:*

#### *Meriter Health Information Management Department to be scanned into the subject’s medical record.*