Allina Health

HIPAA AUTHORIZATION TEMPLATE

- **This HIPAA authorization must be used for studies under the oversight of the Allina IRB or an external IRB under contract with Allina (e.g., Advarra, Western IRB).**
- **The HIPAA authorization should be attached to the end of the consent form after the signature lines for consent.**
- **This template includes instructions in red for creating the form. Prior to uploading this form for IRB review, delete or replace all template instructions (including these introductory instructions), and reformat the document so that the entire form is in black. (To do this, press Ctrl + A at the same time. In the menu bar, select black as the font color.)**

****

HIPAA AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Research Study: [insert study title]

Subject Name: _____

Use and Disclosure of Your Health Information
By signing this form, you are authorizing the use and disclosure (release) of your health information in connection with your participation in the above named research study. Your information will be used only in accordance with the provisions of this authorization as outlined in this form or as required by law.

What Information Will Be Used or Disclosed?
The health information that we may use or disclose (release) for this research includes: **[Insert specific description of health 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, x-rays, MRIs, or certain health information indicating or relating to a particular condition]. [Optional: It also includes all information you may provide us through [insert other information that may be obtained from patient (e.g., surveys), or otherwise.]**

Who Will Receive, Use, and/or Disclose the Information?
The following person(s), class(es) of persons, and/or organization(s) may use, receive, and/or disclose the information connected with this study listed below. These persons are authorized to use and disclose the information to the other parties on this list, to you or your personal representative, or as permitted by law. **[Add requested information on names/classes of recipients of PHI. Delete all categories that do not apply. Note that when the specific individual may change over the course of the project it is preferable to list their class as**

Attach Patient Sticker Here

opposed to specific names. For example reference the "research coordinator" as opposed to the name of the current individual performing that role.]

- The following health care facilities or research site(s) and research staff involved in this study: _____ **[list]**
- Health care providers at Allina Health System
- Laboratories and other individuals and organizations that analyze your health information used in this study as outlined in the study protocol
- The following research sponsors: _____ **[list]**
- The United States Food and Drug Administration (FDA)
- The Office for Human Research Protections in the U.S. Department of Health and Human Services
- A Data Safety Monitoring Board or Committee (A DSMB or DSMC is an independent group who will review study data throughout the study)
- The members and staff of the Institutional Review Board (IRB) that approved this study
- Principal Investigator: _____ **[name]**
- Additional members of the Research Team **[individual names not required]**
- All persons and entities engaged by the Provider, Allina Health System, or the Research Team to assist in managing, analyzing, storing, or transmitting the information.
- Personnel within Allina Health System who are responsible for the administration or oversight of research.
- Others: _____

We cannot prevent re-disclosure of your health information by anyone who receives the information under this authorization, and the information may not be covered by state and federal privacy protections after it is released.

How Will the Information be Used and Disclosed?

Your health information will be:

- Used and disclosed for purposes of the study, including [**describe how information will be used and disclosed for the study (for example, gathering information for the study, monitoring your safety and the overall safety of the study, and for analyzing study data.**]
- **[Insert the following, if applicable: *The researchers conducting this study would like to use your health information for future research purposes. Authorizing use of your health information for these additional purposes is voluntary and does not impact your ability to participate in this study. Please initial here to authorize the use of your health information for these additional purposes: _____ (Patient's Initials)*]**;
- Combined with information about other people who participate in the study;

Attach Patient Sticker Here

- Placed in your medical record at Allina Health Systems; and
- Disclosed to persons listed in this authorization for purposes of the study or as otherwise permitted or required by law.

In order to participate in this study, you must agree to share your information with the groups above by signing this Authorization. You do not have to sign this Authorization, but if you do not, you will not be able to participate in this research study. Refusing to sign this authorization will not affect your current or future care at Allina Health System and will not cause any penalty or loss of benefits to which you are otherwise entitled.

When Access to Your Information May Be Limited
[Choose appropriate language]
[*Your right to access your medical record is not affected by your participation in this project*.]
OR
[*You have the right to review and copy your health information related to this study for as long as the Research Team or institution holds this information. However, to ensure the scientific integrity of the study, you will not be able to review or copy some of the study information until after the study has been completed.*]

The Notice of Privacy Practices, available in the **[hospital, clinic, or office]** where this research is being conducted, provides general information on your rights to review, copy, and correct your health information.

Revocation (cancellation)
If you decide to end your participation in the study or if you are removed from the study by the principal investigator, you may cancel your authorization to use or disclose your health information by notifying **[insert individual to be contacted to terminate authorization]** in writing at **[insert address for contact]**. Your cancellation will be effective after the date it is received. Any health information about you that has already been collected may still be used or disclosed to maintain the integrity or reliability of the research.

Expiration
This authorization for the use and/or disclosure of your health information will not expire unless or until you revoke it.

_____	_____
Printed name of participant or participant's personal representative	If applicable, description of the personal representative's authority to sign for participant
_____	_____
Signature	Date

Attach Patient Sticker Here

_____	_____
Printed name of person obtaining authorization	Role in study
_____	_____
Signature of person obtaining authorization	Date

Attach Patient Sticker Here