**Institutional Review Board for Protection of Human Subjects**

Office of Research and Economic Development

University of Wyoming

**AUTHORIZATION TO USE OR DISCLOSE**

**PROTECTED HEALTH INFORMATION FOR RESEARCH**

**(MEDICAL RELEASE FORM)**

*An additional informed consent document for research participation may also be required.*

Title of research project:

Principal investigator:

Mailing address:

Telephone number:

Email:

If you decide to join this research project, University of Wyoming (UW) researchers may be **using** (collecting) or **sharing** (disclosing) information about you that is considered to be protected health information (private information) for their research.

**Using (collecting)** protected health information refers to researchers obtaining information not directly from you through your participation in this specific research project but obtaining your protected health information from a second party, e.g., your personal physician, pre-existing health records, etc.

**Sharing** of protected health information refers to researchers sharing/communicating your protected health information that they obtain because you are participating in this specific research project with a second party, e.g., your personal physician. Below you will be able to identify the second parties whom the researchers may collect and/or share your protected health information with.

**Protected health information to be used or shared.** Federal law requires that researchers get your permission (authorization) to use or share your protected health information. If you give permission, the researchers may use or share only with the people identified in this Authorization any protected health information related to this research from your medical records and from any test results obtained from this research. Information, used or shared, may include but is not limited to the following:

1. All information relating to tests, procedures, surveys, or interviews as outlined in the consent form;
2. Medical records and charts; and/or
3. Name, address, telephone number, date of birth, race, and government-issued identification number.

**Purposes for using private information.** If you give permission, the researchers may use your protected health information for the purposes of:      .

**Sharing of private information.** If you give permission, the researchers may share your protected health information with the research sponsor, the UW Institutional Review Board, auditors and inspectors who check the research, and government agencies such as the Department of Health and Human Services (HHS). The researchers may also share your information with the following named persons/groups (including physical address):      .

**Using (collecting) private information.** If you give permission, the researchers may collect your protected health information from the following named persons/group (including physical address):      .

**Expiration date or event.** If you give permission, the researchers can use your protected health information until      . (NOTE TO RESEARCHERS: If the information will be kept indefinitely, state that there is no expiration date.)

**Confidentiality.** Although the researchers may report their findings in scientific journals or meetings, they will not identify you in their reports. The researchers will try to keep your information confidential, but confidentiality is not guaranteed. Any person or organization receiving the information based on this authorization could re-release the information to others and federal law would no longer protect it.

**Voluntary choice.** The choice to give UW researchers permission to use (collect) or share your private health information for their research is voluntary. It is completely up to you. No one can force you to give permission. However, you must give permission for UW researchers to use or share your protected health information.

**Revoking permission.** If you give UW researchers permission to use or share your private information, you have a right to revoke your permission whenever you want. However, revoking your permission will not apply to information that the researchers have already used, relied on, or shared. You may revoke your permission at any time by writing to      .

**Giving permission.** By signing this form, you give UW and UW’s researchers led by       permission to (check all that apply):

[ ]  Use (collect) my protected health information

[ ]  Share my protected health information

**Subject name:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name

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Signature of subject Date

Or parent if subject is a child (age 17 or under)

OR

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of legal representative\* Date

\*If signed by a legal representative of the subject, provide a description of the relationship to the subject and the authority to act as legal representative:

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UW may ask you to produce evidence of your relationship.

**A signed copy of this form must be given to the subject or the legal representative at the time this signed form is provided to the researcher.**