**University of Arkansas for Medical Sciences HIPAA Authorization Form**

* **Health Insurance Portability and Accountability Act of 1996) is United States legislation that provides data privacy and security provisions for safeguarding medical information.**
* **The word “you” means both the person who takes part in the research, and the person who gives permission to be in the research. This form and the research consent form need to be kept together.**

We are asking you to take part in the research described in the consent form. To do this research, we need to collect health information that identifies you. We may collect the following information from your medical record:

* <*list specific information that will be recorded*>.

This information will be used for the purpose of <*list purpose of study*>. We will only collect information that is needed for the research. Participating in this research study will create the following new health information:

* <*list information that will be created*>.

For you to be included in this research, we need your permission to collect, create and share this information.

We will, or may, share your health information with people at the University of Arkansas for Medical Sciences (UAMS) who help with the research or things related to the research process, such as the study staff, the UAMS Institutional Review Board and the research compliance office at the University of Arkansas for Medical Sciences. We may share your information with the following researchers outside of the University of Arkansas for Medical Sciences:

* <*list who*>.

We may also share your information with companies that pay for all or part of the research or who work with us on the research, such as the Sponsor listed above, or their legally authorized representative, or anyone who might purchase those companies at a later date. Additionally, we may need to share your health information with people outside of UAMS who make sure we do the research properly, such as the Office for Human Research Protections or the Food and Drug Administration. We believe that those involved with research understand the importance of preserving the confidentiality of your health information. However, some of the people outside of UAMS may share your health information with someone else. If they do, the same laws that UAMS must obey may not apply to others to protect your health information.

This authorization to collect, use and share your health information expires at the end of the research <*or list other date/event if applicable or indicate that it does not expire*.>

If you sign this form, you are giving us permission to create, collect, use and share your health information as described in this form. You do not have to sign this form. However, if you decide not to sign this form, you cannot be in the research study. You need to sign this form and the research consent form if you want to be in the research study.

If you sign this form but decide later that you no longer want us to collect or share your health information, you must send a letter to Principal Investigator:

Principal Investigator

University of Arkansas for Medical Sciences, Slot # *xxx*

4301 W. Markham Street

Little Rock, Arkansas 72205

The letter needs to be signed by you, should list the “Study Title” listed on this form, and should state that you have changed your mind and that you are revoking your “HIPAA Research Authorization”. You will need to leave the research study if we cannot collect and share any more health information. However, in order to maintain the reliability of the research, we may still use and share your information that was collected before the Principal Investigator received your letter withdrawing the permissions granted under this authorization.

<*This paragraph only if records access may be temporarily denied; delete if not applicable*>.

During the course of the study, you may be denied access temporarily to certain medical information about you that is study related. However, the Principal Investigator and staff will not automatically deny a request, but will consider whether it is appropriate under the circumstances to allow access. If access is denied during the study, once the study is completed, you will be able to request access to the information again.

If you decide not to sign this form or change your mind later, this will not affect your current or future medical care or benefits at the University of Arkansas for Medical Sciences.

SIGNATURE, DATE, AND IDENTITY OF PERSON SIGNING

The health information about \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ can be collected and used by the researchers and staff for the research study described in this form and the research consent form.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

Print name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to participant:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The researcher will give you a copy of the signed form.