Hello and thank you for accessing this form from the University of Maryland, Baltimore County Institutional Review Board web site.

Prior to submitting, please ensure that spelling and grammar are correct; this will assist in the timely review of this form during the IRB evaluation process.

Enter information by clicking the  box or typing in the **Click here to enter text.** area.

**Please go to UMBC** [**IRB website**](http://research.umbc.edu/institutional-review-board-human-subjects/) **for all up-to date guidance and information regarding the below questions.**

***[Note: Information in the Authorization should NOT conflict with the consent form.]***

The privacy law, Health Insurance Portability & Accountability Act (HIPAA), protects my individually identifiable health information (protected health information). The privacy law requires me to sign an authorization (or agreement) so researchers can use or disclose my protected health information for research purposes. My protected health information will be used and/or disclosed for the following research study: Click here to enter text.(IRB#Click here to enter text.)

I authorize Click here to enter text.(researcher’s name and address) and the researcher’s staff to create, access, use and disclose my protected health information for the purposes described below.

**My protected health information that may be used and disclosed includes** (list all of the protected health information*1* to be collected for this protocol/study such as demographic information, results of physical exams, blood tests, X-rays, and other diagnostic and medical procedures as well as medical history*)***:**

Click here to enter text.

**My protected health information will be used for** (provide a brief description of ***each*** research project or use information from purpose section in the consent form; indicate that PHI is necessary to conduct the research, and meet legal or institutional requirements):

Click here to enter text.

**The Researchers may use and share my health information with** (the information listed in this section should include all the agencies/researchers included in the consent form; however, the authorization may require additional information or more specific information than the consent form):

List names, addresses, telephone/fax numbers:

Click here to enter text.

Click here to enter text.

Click here to enter text.

Should my health information be disclosed to anyone outside of the study, the information may no longer be protected by HIPAA and this authorization; however, the use of my health information would still be regulated by applicable federal and state laws.

**Right to Refuse to Sign this authorization**

If I decide not to sign the Authorization:

* It will not affect my treatment, payment or enrollment in any health plans or affect my eligibility for benefits.
* I may not be allowed to participate in the research study or receive any research related treatment

*1- Name, address, dates directly related to an individual, telephone/fax number, e-mail/internet protocol or web URL address, Social Security Number, medical record or health plan number, account number, certificate of license number, photographic images, vehicle identifiers, device identifiers, biometric identifiers, any other unique code*

**Right to Revoke**

After signing the Authorization, I can change my mind and:

* Not let the researcher(s) disclose or use my protected health information (revoke the Authorization).
* If I revoke the Authorization, I will send a written letter to Click here to enter text. (researcher’s name and address) to inform the researcher of my decision.
* If I revoke this Authorization, researchers may only use and disclose the protected health information **already** collected for this research study.
* If I revoke this Authorization my protected health information may still be used and disclosed should I have an adverse event (a bad effect).
* If I change my mind and withdraw the authorization, I may not be allowed to participate in the study.

This Authorization does not have an expiration date.

**I am the research participant or am authorized to act on behalf of the participant. I have read this information, and I will receive a copy of this form after it is signed.**

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Signature of research participant or the research Date  
participant’s legal representative

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Printed name of research participant or Representative’s relationship to   
research participant’s legal representative research participant

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

(hipaaauthorization.doc) –09/10/2015