ANNALS OF FAMILY MEDICINE

Online Supplementary Material

Pace WD, Staton EW, Holcomb S. Practice-based research network studies in the age of HIPAA. *Ann Fam Med.* 2005;3(Suppl 1):S38-S45.

http://www.annfammed.org/cgi/content/full/3/suppl_1/S38

Supplemental Appendix 1. Example of an Authorization for Research

Authorization to Use or Release Health Information About Me for Research Purposes ***Authorization B: Enrollment Into Research***	**Study Title:**

I _____*(Patient's Full Name)* **authorize** _____ *(PI's or Physician's Name)* **and staff members of** _____ *(Facility Name)* **working for him/her to use the following health information about me <u>for research</u>:** *(Please check the appropriate boxes. NOTE: If a category is checked Yes and a line follows the category, you MUST describe the type of the procedures done.)*

No Yes

☐ ☐ Name and/or phone number
☐ ☐ Demographic information (age, sex, ethnicity, address, etc)
☐ ☐ Diagnosis(es)
☐ ☐ History and/or physical
☐ ☐ Laboratory or tissue studies: _____
☐ ☐ Radiology studies: _____
☐ ☐ Testing for or infection with human immunodeficiency virus (HIV) (or results)
☐ ☐ Procedure results: _____
☐ ☐ Psychological tests: _____
☐ ☐ Survey/questionnaire: _____
☐ ☐ Research visit records
☐ ☐ Portions of previous medical records that are relevant to this study
☐ ☐ Billing or financial information
☐ ☐ Drug abuse
☐ ☐ Alcoholism or alcohol abuse
☐ ☐ Sickle cell anemia
☐ ☐ Other (specify): _____

For the Specific Purpose of

☐ Collecting data for this research project
☐ Other*: _____

**Cannot say "for any and all research," "for any purpose," etc*

If my health information that identifies me is also going to be given out to others outside the facility, the recipients are described on the next page(s).

☐ **No personally identifiable health information about me will be disclosed to others.**

The PI (or staff acting on behalf of the PI) will also make the following health information about me available to: (check all that apply and **describe the type of the procedures done** where applicable)

Recipient (name of person or group) _____

No Yes

☐ ☐ All research data collected in this study (if you check this box Yes, no other boxes need to be checked in this section)

☐ ☐ Name and phone number
☐ ☐ Demographic information (age, sex, ethnicity, address, etc)
☐ ☐ Diagnosis(es)
☐ ☐ History and physical
☐ ☐ Laboratory or tissue studies: _____
☐ ☐ Radiology studies: _____
☐ ☐ Testing for or infection with human immunodeficiency virus (HIV) (or results)
☐ ☐ Procedure results: _____
☐ ☐ Psychological tests: _____
☐ ☐ Survey/questionnaire: _____
☐ ☐ Research visit records
☐ ☐ Portions of previous medical records that are relevant to this study
☐ ☐ Billing or financial information
☐ ☐ Drug abuse
☐ ☐ Alcoholism or alcohol abuse
☐ ☐ Sickle cell anemia
☐ ☐ Other (specify): _____

For the Specific Purpose of

☐ Evaluation of this research project
☐ Evaluation of laboratory/tissue samples
☐ Data management
☐ Data analysis
☐ Other*: _____

**Cannot say "for any and all research," "for any purpose," etc*

For additional Recipients, copy this page as needed.

I give my authorization knowing that:

- I do not have to sign this authorization. But if I do not sign it, the researcher has the right to not let me be in the research study.
- I can cancel this authorization any time.
  - I have to cancel it in writing.
  - If I cancel it, the researchers and the people the information was given to will still be able to use it because I had given them my permission, but they won't get any more information about me.
  - If I cancel my authorization, I may no longer be able to be in the study.
  - I can read the Notice of Privacy Practices at the facility where the research is being conducted to find out how to cancel my authorization.
- The records given out to other people may be given out by them and might no longer be protected.
- I will be given a copy of this form after I have signed and dated it.

This authorization will expire on**:** _____ (Date) OR
☐ The end of the research study
☐ Will not expire
☐ _____
(Describe dates or circumstances under which the authorization will expire.)

ADDITIONAL INFORMATION: _____

_____

_____

_____
Patient's Signature Date

_____
Signature of Legal Representative (if applicable) Date

_____
Name of Legal Representative (please print)

_____
Description of Legal Authority to Act on Behalf of Patient

Adapted with permission from the Colorado Multiple Institutional Review Board (COMIRB), http://comirbweb.uchsc.edu.