Health Insurance Portability and Accountability Act (HIPAA)
AUTHORIZATION TO OBTAIN, USE AND DISCLOSE
PROTECTED HEALTH INFORMATION FOR RESEARCH

Attachment **# 19**: **HIPAA Authorization**

POPULATION CONTROLS

Name of Study Volunteer: _____

Date of Birth: _____

NAME OF THIS RESEARCH STUDY: Resource Collection and Evaluation of Human Tissues and Cells from Donors with an Epidemiology Profile for NCI Contract # NO2-RC-5770

UMB IRB APPROVAL NUMBER: HP-42163

RESEARCHER'S NAME: DR. DEAN MANN

RESEARCHER'S CONTACT INFORMATION:

Department of Pathology
University of Maryland School of Medicine
(UMSOM)
22 South Greene St. P3G12
410-328-5512

This research study will use health information that identifies you. If you agree to participate, this researcher will use just the health information listed below.

THE SPECIFIC HEALTH INFORMATION TO BE USED OR SHARED:

- *Health-related information you have been asked to provide for the study during interviews, via a questionnaire.*

Federal laws require this researcher to protect the privacy of this health information. He will share it only with the people and groups described here.

PEOPLE AND ORGANIZATIONS WHO WILL USE OR SHARE THIS INFORMATION:

- Dr. Mann and his research team.
- The National Cancer Institute, Laboratory of Human Carcinogenesis
- Research Staff at Georgetown University School of Medicine

THIS AUTHORIZATION WILL NOT EXPIRE. BUT YOU CAN REVOKE IT AT ANY TIME.
To revoke this Authorization, send a letter to this researcher stating your decision. He will stop collecting health information about you. This researcher might not allow you to continue in this study. He can use or share health information already gathered.

- *There is no scheduled date at which this information will be destroyed or no longer used. This is because information that is collected for research purposes may be analyzed for many more years and it is not possible to determine when analysis will be complete.*

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ADDITIONAL INFORMATION:

- You can refuse to sign this form. If you do not sign it, you cannot participate in this study.
- Sometimes, government agencies such as the Food and Drug Administration or the Department of Social Services request copies of health information. The law may require this researcher, the UMSOM, UPI,UMMS or VAMHCS to give it to them.
- This researcher will take reasonable steps to protect your health information. However, federal protection laws may not apply to people or groups outside the UMSOM, UMB, UPI, UMMS or VAMHCS.
- Except for certain special cases, you have the right to a copy of your health information created during this research study. You may have to wait until the study ends. Ask this research how to get a copy of this information from him.

My signature indicates that I authorize the use and sharing of my protected health information for the purposes described above. I also permit my doctors and other health care providers to share my protected health information with this researcher for the purposes described above.

Signature: _____ Date: _____

Name (printed) _____

Privacy Questions? Call the UMSOM Privacy Official (410-706-0337) with questions about your rights and protections under privacy rules.

Other Questions? Call the researcher named on this form with any other questions.