IRB Protocol Number: 20070461	**Principal Investigator:** Neil Schneiderman, PhD
Departmental Study Code:	

HIPAA Research Authorization Template – Form B
AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I agree to permit the ☒ *University of Miami* ☐ *Jackson Health System* ☐ *both*, and any of my doctors or other health care providers (together "Providers"), Principal Investigator and [*his /her/their/its*] collaborators and staff (together "Researchers"), to obtain, use and disclose health information about me as described below.

1. **The health information that may be used and disclosed includes:** all information collected during the research and procedures described in the Informed Consent Form for

   - the Research as described in the accompanying Informed Consent Form ("the Research"); and
   - health information in my medical records that is relevant to the Research, includes my past medical history including medical information from my primary care physician and other medical information relating to my participation in the study; and
   - health information in my medical records pertaining to HIV status, including my HIV test results (if applicable).

2. **The Providers may disclose health information in my medical records to:**
   - the Researchers;
   - representatives of government agencies, any applicable Cooperative Groups, review boards, and other persons who watch over the safety, effectiveness, and conduct of research; and
   - the sponsor of the Research, National Institutes of Health ,
     (Print Sponsor Name)
     and its agents and contractors (together "Sponsor").

3. **The Researchers may use and share my health information:**
   - among themselves, with the Sponsor, with any applicable Cooperative Groups, and with other participating Researchers to conduct the Research; and
   - as permitted by the Informed Consent Form.

4. **The Sponsor and any applicable Cooperative Groups may use and share my health information** for purposes of the Research and as permitted by the consent form.

5. **Once my health information has been disclosed to a third party,** federal privacy laws may no longer protect it from further disclosure.

6. **Please note that:**
   You do not have to sign this Authorization, but if you do not, you may not participate in the Research. If you do not sign this authorization, your right to other medical treatment will not be affected.

University of Miami - Office of HIPAA Privacy and Security
PO BOX 019132 (M879) **hipaaprivacy@med.miami.edu**
Miami, FL 33101 **(305) 243-5000**

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Form D3901001E

Revised 03/27/06

Required Information: ***Please Complete.***

NAME:_____

MRN:_____ ☐ **IDX** ☐ **SMS**

☐ **SS #** ☐ **DL #** ☐ **PASSPORT #** ☐ **OTHER**_____

ID#:_____

AGE:_____ **DOB:** ____/____/____

DATE OF SERVICE: _____/_____/_____

You may change your mind and revoke (take back) this Authorization at any time and for any reason. To revoke this Authorization, you must write to either of the following:

***Research Study Personnel Name:** Dr. Marc Gellman

Address: 1120 NW 14th Street, Room 1518, Miami, FL 33136

Tel. No.: 305-243-2044

Human Subjects Research Office
Address: 1500 NW 12th AVE, Suite 1002 Miami, FL 33136
Tel. No.: (305) 243-3195

However, if you revoke this Authorization, you will not be allowed to continue taking part in the Research. Also, even if you revoke this Authorization, the Providers, Researchers, any applicable Cooperative Groups and the Sponsor may continue to use and disclose the information they have already collected to protect the integrity of the research or as permitted by the Informed Consent Form.

While the Research is in progress, you may not be allowed to see your health information that is created or collected by the ☒ *University of Miami* ☐ *Jackson Health System* ☐ *both*, in the course of the Research. After the Research is finished, however, you may see this information as described in the ☒ *University of Miami* ☐ *Jackson Health System* ☐ *both*, Notice of Privacy Practices.

*Study personnel must send copies of participant revocations to:
Office of HIPAA Privacy and Security AND the Human Subjects Research Office.

7. **This Authorization does not have an expiration (ending) date.**

8. **You will be given a copy of this Authorization after you have signed it.**

_____ _____
Signature of participant or participant's legal representative — Date

_____ _____
Printed name of participant — Printed name of legal representative (if applicable)

_____
Representative's relationship to participant

Study personnel must send copy with signature to the Office of HIPAA Privacy and Security
For questions, contact the Human Subjects Research Office at 305-243-3195.

