Appendix M
HIPAA Authorization

STUDY ID NUMBER

Authorization for Use or Disclosure of Health Information

Text message intervention for young people living with HIV

Patient Name: ____
First Middle Last

Patient's Date of Birth: __________/___/___________________________
Month/Day/Year

I, the undersigned, authorize the disclosure of individually identifiable health information about me for research, as described below.

Description of information to be disclosed, including dates of service related to such information:

Information to be disclosed includes number of appointments scheduled, number of clinic visits, confirmation of HIV diagnosis, most current HIV viral load test results (the number of HIV copies in a milliliter of blood) and most current CD4 count. This information will be collected four times during the period of enrollment in the study, once at the start of enrollment (on or nearly on the execution date of this authorization), and at or nearly at three month intervals beyond the execution date of this authorization. In addition, some subject's names and telephone numbers will be disclosed for the purposes of contacting those who are selected to participate in in-depth individual interviews. ________________________________

Provider authorized to disclose my health information (provider name and address):

[Study site clinics to be determined.]

Persons or class of persons to whom my health information may be disclosed:

Research staff at RTI International, Research Triangle Park, NC

Purpose for this disclosure of my health information:

This purpose of this study is to explore whether daily text messages about a variety of topics can improve the health of HIV-positive youth. The health information to be disclosed for study purposes with allow for the verification of research participant eligibility based on HIV status (participants must be HIV-positive), evaluate changes in HIV treatment regimens, help to describe the participants in the study in terms of HIV-related clinical outcomes (e.g., CD4 count, viral load measures), provide preliminary evidence of the effectiveness of the text messaging intervention based on change in HIV-related clinical outcomes, and for follow-up contact with subjects selected to participate in in-depth individual interviews.________________

This authorization expires (specific date, time period after signature, or "not applicable"):

INSERT DATE

I understand that I may revoke this authorization at any time by notifying [CLINIC NAME] _____ in writing.

I also understand that I may refuse to sign this authorization and that my refusal will in no way affect my treatment, payment, enrollment in a health plan, or eligibility for benefits.

By signing below, I give permission to the provider named above to release health information about me to staff at RTI International.

Signature of Patient or Patient's Personal Representative:

____

Date: ___________________
Month/Day/Year

For Personal Representative (if applicable):

Printed Name of Personal Representative: ____________________________________
First Middle Last

Nature of Personal Representative Relationship/Authority to Act for the Patient

(parent, guardian, etc.): ____

Disposition: Original to RTI; Copy kept by patient [RTI Project Number: 0213543.001]

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