

## MUH Adult Resident HIPAA Authorization

### LOS ANGELES COUNTY PUBLIC HEALTH IRB AUTHORIZATION FOR

#### USE AND DISCLOSURE OF HEALTH INFORMATION

#### IN CONNECTION WITH RESEARCH STUDY

#### **The Health Insurance Portability and Accountability Act (HIPAA) and California Law:**

A federal law known as the Health Insurance Portability and Accountability Act (HIPAA) protects how your health information is used for certain purposes.

HIPAA requires that you give your written permission to release your "Protected Health Information" to members of the research team to use for this research study. "Protected Health Information" is any identifiable health information about your past, present or future physical or mental health condition or payment for health care. Examples of protected health information include: medical or dental records, billing records, identifiable tissue samples and x-rays. State law also gives you certain protections regarding the use and release of your health information.

This form authorizes your health care providers to release your health information to members of the research team and others for research purposes. It also describes how your health information will be used. You must sign this form to participate in the study.

#### **Authorization to Obtain and Use Health Information From Provider for Research Study:**

By signing this document, you authorize (give permission to) your health care provider(s) listed or described as:

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To release the following information: *[check the box that applies]*

- D** All of your medical or other patient records and other protected health information that the provider has in his or her possession, including information relating to any patient history, mental or physical condition and any treatment you received. (This section does not include HIV test results, certain inpatient mental health records, and drug and alcohol treatment records protected under federal law, which require your separate authorization below).

- 0** Only the following records or types of health information: (Insert dates of treatment, types of treatment or other designation.)
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- ./ Any and all health information that is generated in the course of the research study

To the following individuals or entities for the following purposes:

- ./ Researchers (those individuals in charge of the study), research staff, including nurses, technicians and administrators, students involved with the research project, such as graduate assistants, medical or professional trainees and other members of the research team for purposes of the research study as described in the attached informed consent

The research sponsor, its affiliates, subcontractors and representatives for purposes of conducting, evaluating, overseeing or otherwise assisting with this research study and the related research activities of the sponsor

The Los Angeles County Department of Public Health Institutional Review Board (IRB), funding agencies and relevant government national and international oversight agencies such as the Food and Drug Administration and the Office for Human Research Protections and as otherwise required by law

**Authorization to Use Health Information for a Research Database:**

Health care researchers will often review existing health information from large groups of patients in order to test or validate theories that the researcher develops. This is sometimes called records research or database research. Los Angeles County Department of Public Health maintains such databases, often grouping together patient information for purposes of future medical or other health research. This authorization also permits Public Health to include the health information about you that Public Health has in its possession in Public Health research databases for the purpose of future medical or other health research.

This authorization only allows Los Angeles County Department of Public Health to use your health information for purposes of entering the data and maintaining the research databases. The Los Angeles County Department of Public Health will not allow researchers further access to the Public Health database for research purposes unless the Los Angeles County Department of Public Health obtains a specific authorization from you or unless such use or disclosure is specifically required or permitted by law.

This section of the Authorization will remain in effect indefinitely from the date of this Authorization.

You are not required to agree to this section in order to participate in the study.

**Limits of this Authorization:**

Under the Los Angeles County Department of Public Health policies, personnel identified above who have access to your health information as part of this study, may not use the information for purposes other than this study, except as otherwise permitted by law. In addition, while health information that is shared with others outside the Los Angeles County Department of Public Health may not be protected by HIPAA once disclosed, it may nonetheless remain protected under relevant California or other state privacy laws.

**Right to Deny Access to Health Information:**

During the course of this study, you may be denied access (to inspect or copy) to some or all information generated for this research study. Subject to applicable law, you are entitled to access this health information once the research study is completed.

**Term of this Authorization:**

Except for database research, if applicable, this authorization for Los Angeles County Department of Public Health to use your health information described above for purposes of the research study expires 3 (THREE) years from the date of your signature or at the end of the research study (including all data collection and analysis), whichever is sooner, unless you revoke this authorization as described in the next section.

**Refusal to sign/Right to Revoke:**

You must sign this Authorization in order to participate in this research. You may change your mind and revoke (e.g., withdraw or cancel) this authorization and your participation in this research study at any time. To do so, your revocation must be in writing to the Los Angeles County Department of Los Angeles County Department of Public Health Institutional Review Board (IRB) and include: (1) the title of the research study; (2) the name of the Principal Investigator; and (3) your name and telephone number or address. Please send the revocation to the following IRB address: Los Angeles County Department of Public Health IRB, 313 N. Figueroa St, Suite 127, Los Angeles, CA 90012.

From and after the date your notice of revocation is received, you will not be allowed to participate any further in the research and we will stop collecting your health information. However, even if you revoke

this authorization and your participation in this research study, we may still use and share your health information already obtained as necessary to maintain the integrity of the research study.

**Questions regarding your privacy rights:**

The address of the Los Angeles County Department of Public Health IRB is 313 N. Figueroa Street, Suite 127, Los Angeles, CA 90012, and you may contact the IRB by telephone at 213-250-8675.

**Agreement:**

I have read (or someone has read to me) the information provided above. I have been given the opportunity to ask questions and all of my questions have been answered to my satisfaction. My signature below indicates that I authorize the use and disclose my health information as described in this document.

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Name of Subject	Signature	Date of Birth	Date Signed
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If Individual is unable to sign this Authorization, please complete the information below:

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Name of Legal Guardian/	Signature	Date
Legal Relationship		
Personal Representative		

**You will be provided with a signed copy of this authorization.**

Form Valid For Enrollment From 05/16/2013      r05/15/2014  Los Angeles County-Public Health Institutional Review Board
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**Note: Below is the document whose language must be included in all informed consent documents in California, or that must be signed as a separate document and included in the study records.**

### HUMAN RIGHTS IN MEDICAL STUDIES

CALIFORNIA LAW REQUIRES THAT YOU MUST BE INFORMED ABOUT:

1. THE NATURE AND PURPOSE OF THE STUDY.
2. THE PROCEDURES IN THE STUDY AND ANY DRUG OR DEVICE TO BE USED.
3. DISCOMFORTS AND RISKS TO BE EXPECTED FROM THE STUDY.
4. BENEFITS TO BE EXPECTED FROM THE STUDY.
5. ALTERNATIVE PROCEDURES, DRUGS OR DEVICES THAT MIGHT BE HELPFUL AND THEIR RISKS AND BENEFITS.
6. AVAILABILITY OF MEDICAL TREATMENT SHOULD COMPLICATIONS OCCUR.
7. THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY OR THE PROCEDURE.
8. THE OPPORTUNITY TO WITHDRAW AT ANY TIME WITHOUT AFFECTING YOUR FUTURE CARE AT THIS INSTITUTION.
9. A COPY OF THE WRITTEN CONSENT FORM FOR THE STUDY.
10. THE OPPORTUNITY TO CONSENT FREELY TO THE STUDY WITHOUT THE USE OF COERCION.
11. STATEMENT REGARDING LIABILITY FOR PHYSICAL INJURY, IF APPLICABLE.

IF YOU HAVE ANY QUESTIONS OR CONCERNS REGARDING THESE RIGHTS OR THE CHARACTER OF THE STUDY, PLEASE FEEL FREE TO DISCUSS THEM WITH THE PERSON(S) CONDUCTING THE STUDY, OR YOU MAY CONTACT THE RESEARCH COMMITTEE CHAIRMAN, LOS ANGELES COUNTY DEPARTMENT OF PUBLIC HEALTH, AT (213) 250-8675.

*I HAVE READ AND UNDERSTOOD MY RIGHTS FOR PARTICIPATION IN THE STUDY.*

SIGNATURE OF SUBJECT OR GUARDIAN  
FIRMA DEL SUJETO O PERSONA RESPONSABLE

\_\_\_\_\_  
DATE  
FECHA

### DERECHOS HUMANOS EN ESTUDIOS MEDICOS

LA LEY DEL ESTADO DE CALIFORNIA REQUIERE QUE UD. TIENE QUE ESTAR INFORMADO SOBRE:

1. LA NATURALEZA Y EL PROPÓSITO DEL ESTUDIO.
2. LOS PROCEDIMIENTOS DEL ESTUDIO Y CUALQUIER FARMACO, APARATO O DISPOSITIVO QUE SE VAYA A UTILIZAR.
3. LAS MOLESTIAS Y LOS RIESGOS QUE SE ANTICIPAN DEL ESTUDIO.
4. LOS BENEFICIOS QUE SE PUEDEN ESPERAR DEL ESTUDIO.
5. LOS PROCEDIMIENTOS ALTERNOS, FARMACOS O DISPOSITIVOS QUE PUEDEN SER ÚTILES Y LOS RIESGOS Y BENEFICIOS QUE ESTOS LLEVAN.
6. DISPONIBILIDAD DE TRATAMIENTO MEDICO EN CASO QUE OCURRAN COMPLICACIONES.
7. LA OPORTUNIDAD PARA HAGER CUALESQUEIRA PREGUNTAS SOBRE EL ESTUDIO O EL PROCEDIMIENTO.
8. LA OPORTUNIDAD PARA RETIRARSE DEL ESTUDIO EN CUALQUIER MOMENTO SIN AFECTAR SU ATENCIÓN MEDICA FUTURA EN ESTA INSTITUCIÓN.
9. UNA COPIA DE ESTE CONSENTIMIENTO FIRMADO PARA EL ESTUDIO.
10. LA OPORTUNIDAD PARA CONSENTIR LIBREMENTE AL ESTUDIO SIN EL USO DE COERCIÓN.
11. DECLARACIÓN ACERCA DE LA RESPONSABILIDAD POR DANOS FISICOS, SI ES APLICABLE.

SI UD. TIENE CUALESQUEIRA PREGUNTAS O PREOCUPACIONES ACERCA DE ESTOS DERECHOS O EL CARACTER DEL ESTUDIO, POR FAVOR SIENTASE LIBRE PARA DICUTIRLOS CON LA(S) PERSONA(S) LLEVANDO A CABO EL ESTUDIO, O UD. PUEDE PONERSE EN CONTACTO CON EL PRESIDENTE DEL COMITE INVESTIGATIVO DEL CONDADO DE LOS ANGELES SALUD PUBLICA, A (213) 250-8675.

*YO HE LEIDO ESTE DOCUMENTO Y ENTIENDO MIS DERECHOS PARA MI PARTICIPACIÓN EN EL ESTUDIO.*

Form Valid For Enrollment From

05/16/2013 05/15/2014

Los Angeles County-Public Health

