OMB #: 0925-0593
OMB Expiration Date: 08/31/2014

National Children's Study

HIPAA Authorization for the Use and Disclosure of Health Information

Primary health care provider

Facility

Street address

City

State Zip

Phone number

Place Label Here

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
National Institutes of Health
Centers for Disease Control and Prevention
U.S. ENVIRONMENTAL PROTECTION AGENCY

Name of other health care provider

Facility

Street address

City

State Zip

Phone number

Place Label Here

Name of other health care provider

Facility

Street address

City

State Zip

Phone number

Place Label Here

Name of other health care provider

Facility

Street address

City

State Zip

Phone number

Place Label Here

Name of other health care provider

Facility

Street address

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Place Label Here

This is a permission form called a HIPAA Authorization Form for the Use and Disclosure of Health Information. It is required by the Health Insurance Portability and Accountability Act of 1996 (known as HIPAA)[1] in order to collect protected health information from your/your child(ren)'s medical and health records to use in the National Children's Study (NCS). Protected health information (PHI) is any identifiable health information about your/your child(ren)'s past, present, or future physical or mental health condition or payment for health care. Examples of PHI are medical and dental records, billing records, x-rays, ultrasound, and laboratory reports.

If you sign this form, you agree that you are voluntarily participating in the NCS and you authorize the health care providers identified above to release your/your child(ren)'s PHI to members of the NCS research team. If you sign this form, you are authorizing the release of PHI from you and your child(ren) regarding prenatal, medical, mental health, clinical, or diagnostic services such as ultrasound, labor and delivery, or perinatal services, treatments, testing, and test results provided to you/your child(ren) during and following your current pregnancy. This authorization form covers any care you/your child(ren) received from other health care providers associated with the above identified health care providers or facility(s) who provided care to you/your child(ren), such as laboratories and diagnostic centers.

The NCS and its contractors will use this information for research purposes only and to supplement the information you have already given to the research team. Once your information is released to the NCS, it is no longer covered by HIPAA but is covered by the Privacy Act of 1974, Titles II and III of the E-Government Act (FISMA) and the Public Health Service Act[2], which prohibits the release of information that would identify you and your child(ren) or health care providers without your permission or that of your health care providers. Any NCS generated information incorporated into your/your child(ren)'s medical record(s) maintained at the facility(s) mentioned above will be covered by the same HIPAA privacy laws as the rest of your/your child(ren)'s medical information. Your decision to sign or not to sign this form will have no effect on your/your child(ren)'s eligibility for treatment with the health care provider identified above or at this facility. In addition, it will have no effect on payment, enrollment, or eligibility for any benefits to which you/your child(ren) are entitled.

You have the right to stop this HIPAA authorization at any time. You must do so in writing by sending a letter to the Study representative as indicated below. Stopping this HIPAA authorization will not stop information sharing that has already happened. Otherwise, this authorization does not have an expiration date. For questions about this release, please contact the NCS Office at [(XXX) XXX-XXXX].

You will be given a copy of this HIPAA Authorization Form.

I authorize the NCS to use the information I have given in this form to access and obtain copies of my/my child(ren)'s medical records or PHI.

_____ _____

Printed name of participant (first, middle, last) Other names under which records may be filed

Date of birth: ☐☐/☐☐/☐☐☐☐
m m d d y y y y

_____ Date signed: ☐☐/☐☐/☐☐☐☐
Signature of participant m m d d y y y y

_____ Date signed: ☐☐/☐☐/☐☐☐☐
Witness or Proxy's signature m m d d y y y y

_____ Reasons for Witness or Proxy's Signature:
Signer's relationship to participant ❒ Patient Disabled ❒ Patient Deceased

If the participant is a non emancipated minor, according to state law, a parent/guardian must sign and date.

_____ Date signed: ☐☐/☐☐/☐☐☐☐
Signature of parent/guardian m m d d y y y y

1. Health Insurance Portability and Accountability Act: 42 U.S.C. 1320d-2 and 1320d-4 and the implementing regulation, 45 CFR 164.508, require a detailed authorization for your health care provider to disclose health information from your records for research purposes.

2. Public Health Service (PHS) Act: 42 U.S.C. 242m(d) protects the confidentiality of data collected under the research authorities of the National Institutes of Health. The National Children's Study will be carried out in compliance with these provisions as well as those in the Children's Health Act of 2000 (Public Law 106-310 Sec. 1004).

Affix label with local contacts:
1. Rights as a Human Subject
2. Local Site Office