Form Approved

OMB No. 0920-New

Expiration Date: XX/XX/XXXX

Using Real-time Prescription and Insurance Claims Data to Support the HIV Care Continuum

Attachment 8d

HIPPA authorization – participants

Public reporting burden of this collection of information is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; Attn: OMB-PRA (0920-New)

To be read on the phone after the informed consent process.

As part of this research study, we will ask you to share identifiable health information with us and/or permit us to access existing information from your healthcare records. This type of information is considered "Protected Health Information" that is protected by federal law. The data will come from insurance records from Virginia Medicaid and from routine HIV surveillance records collected by the Virginia Dept of Health.

To conduct of this research we may use: Diagnosis & treatment codes, Laboratory test results, , Your complete billing record, Your itemized billing information, Information about drug or alcohol abuse, and Information about psychiatric care.

By agreeing to this study, you authorize VCU and VCU Health to use and/or share your health information for this research. The health information just described may be used by and/or shared with the following people and groups to conduct, monitor, and oversee the research: the Principal Investigator and Research Staff, Research Collaborators (including VDH, UVA, and VDMAS), , Institutional Review Boards, and Others as Required by Law. Once your health information has been disclosed to anyone outside of this study, the information may no longer be protected under this authorization.
This authorization will expire when the research study is closed, or there is no need to review, analyze and consider the data generated by the research project, whichever is later.

You may change your mind and take back the right to use your protected health information at any time. However, even if you take back your Authorization, the researchers may still use or release any health information that they have already collected about you for the study. If you take back this Authorization, you may no longer be allowed to participate in the research study. To take back this Authorization, you must write to Dr. April Kimmel, the Principal Investigator, at 830 East Main Street, Richmond, VA 23219.

Do you have any questions about how your health information will be used and released in this study?

Do you agree that health information that identifies you may be used and disclosed for this research as we previously described?

_____ YES _____ NO