Red Carpet Entry (RCE) Program Implementation Project

Attachment # 4c

HIPAA Authorization (English)

HIPAA Authorization

STUDY ID NUMBER

Authorization for Use or Disclosure of Health Information

Red Carpet Entry

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 clinic appointments and attendance, confirmation of HIV diagnosis, and demographic information such as age, sex, and race/ethnicity. This information will be collected during the period of enrollment in the study. In the event that [clinic]'s normal operations are stopped due to COVID-19, the study/ period of enrollment will be extended by up to four months.

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

[Site's name and address]

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

Research staff at RTI International, Research Triangle Park, NC

Study staff at the Centers for Disease Control and Prevention, Atlanta, GA

Purpose for this disclosure of my health information:

This purpose of this study is to test an intervention that aims to help improve the health and wellbeing of people with HIV. The health information to be disclosed for study purposes will provide evidence of the effectiveness of the Red Carpet Entry program based on changes in HIV service-related outcomes_____

This authorization expires at the end of the research study.

I understand that I may take back 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 for the research purposes described above. I also understand that persons who received my health information may not be required by Federal privacy laws (Privacy Rule) to protect it and may share my information with others without my permissions, if permitted by law governing the type of data.

We can give you an unsigned copy of this form if you would like.

_____

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.): _____