AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION THAT IDENTIFIES YOU FOR A RESEARCH STUDY

NHRC.2021.0018

Principal Investigator (PI) Name and Rank: Hope M. McMaster, Ph.D.

Corps and Service/Organization: Naval Health Research Center (NHRC)

Title of Research Study: Millennium Cohort Study of Adolescent Resilience (SOAR)

I. Purpose of this Document

An Authorization is your permission to use or disclose your health information. The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, as implemented by the Department of Defense (DoD), permits the Military Health System (MHS) to use or disclose your health information with a valid Authorization. The MHS is defined as all DoD health plans and DoD health care providers that are organized under the management authority of, or in the case of covered individual providers, assigned to or employed by, the Defense Health Agency (DHA), the Army, the Navy, or the Air Force. A valid Authorization must include the core elements and required statements as contained in this document.

The purpose of this form is to give your permission to the research team at the Naval Health Research Center (NHRC) to obtain, use or share your protected health information (PHI). This protected health information will be used to do the research named above. NHRC understands that information about you and your health is personal and we are committed to protecting the privacy of that information in accordance with state and federal privacy laws. Because of this commitment, we must obtain your written authorization before we may collect, use or share your protected health information for the research study listed above. This form provides authorization and helps us make sure you are properly informed of how this information will be used or disclosed. You do not have to check the box at the end of this permission form. If you do not check the box on this form, NHRC will not obtain, use or share your protected health information for research. Your decision to not check the box on this permission will not affect any treatment, health care, enrollment in health plans or eligibility for benefits.

Please read the information below and ask questions about anything you do not understand before deciding to give permission for the use and disclosure of your health information.

II. Authorization

The following describes the purposes of this research study:

The Office of the Deputy Assistant Secretary of Defense (DASD) for Military Community and Family Policy (MC&FP) is sponsoring this research to understand the needs of military-connected youth and their families. The overarching aim of this study is to assess how military experiences are related to adolescents' psychosocial adjustment and physical health, academic achievement, and educational/military career aspirations and to identify risk and protective factors that may increase or decrease positive outcomes among military-connected adolescents and their families.

A. What health information will be used or disclosed about you?

If you check the box at the end of this form, you give NHRC permission to obtain, use, or share the following health information as part of this research study: Medical history including results of physical examinations, lab tests, or certain health information indicating or relating to a particular condition; treatment and health services; hospital discharge summary; emergency department records; psychological testing; progress notes; and financial billing records.

B. Who will be authorized to use or disclose (release) your health information to the researcher for this study?

The health information described above may be generated or obtained from:

1. Research survey data collected from you during the course of this research study.
2. Healthcare provider(s) who provided services to you or analyze your health information for clinic use within the TRICARE Prime, Standard, Select, or TRICARE remote networks.

   Any protected health information disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and is no longer protected.

C. Who may receive your health information?

If you agree to be in this study, the research team may use or share your protected health information in the following ways:

- The NHRC research team will receive and process your protected health information. Once all research records collected about you in support of this study have been obtained and merged with your health information, all subject identifiers will be removed from final analytic datasets. The NHRC research team will use this information for the research described in the research consent form.
- Any collaborator outside of the NHRC research team will receive access to final deidentified datasets. No individually identifying information will be shared with collaborators outside of the NHRC research team.
- IRBs, Data Safety and Monitoring Boards, and others with authority to oversee the research may have access to your records to ensure compliance with all DoD regulations and with required protocols for the protection of research participants.

D. What if you decide not to give permission for this Authorization?

You do not have to check the box at the end of this Authorization. If you do not check the box, NHRC will not obtain, use, or share your protected health information for research. Your decision not to check the box on this Authorization will not affect any treatment, health care, enrollment in health plans or eligibility for benefits, even those that may be associated with this study. The MHS **will not** condition (withhold or refuse) treatment that is not part of this study, payment, enrollment, or eligibility for benefits on whether you check the box on this Authorization.

E. Is your health information requested for <u>future</u> research studies?

No, your health information ***<u>is not</u>*** requested for future research studies.

F. Can you access your health information during the study?

You may have access to your health information at any time, unless your identifiers are permanently removed from the data. Identifiers will be retained during and for a period of 5 years after completion of this study. To obtain a copy of your personal research records, you may submit a written request to the study Principal Investigator:

Hope M. McMaster, Ph.D.
Naval Health Research Center
140 Sylvester Road
San Diego, CA 92106-3521

G. Can you revoke this Authorization?

- You may change your mind and revoke (take back) your Authorization at any time. However, if you revoke this Authorization, any person listed above may still use or disclose any already obtained health information as necessary to maintain the integrity or reliability of this research.
- If you revoke this Authorization, you may no longer be allowed to participate in this research study.
- If you want to revoke your Authorization, you must contact the Study PI, Dr. Hope McMaster, via email at hope.m.mcmaster.civ@health.mil, or write to:

Hope M. McMaster, Ph.D.
Naval Health Research Center
140 Sylvester Road
San Diego, CA 92106-3521

H. Does this Authorization expire?

Yes, it expires at the end of the research study.

I. What else may you want to consider?

- No publication or public presentation about the research described above will reveal your identity without another Authorization from you.
- If all information that does or can identify you is removed from your health information, the remaining de-identified information will no longer be subject to this Authorization and may be used or disclosed for other purposes.
- In the event your health information is disclosed to an organization that is not covered by HIPAA, the privacy of your health information cannot be guaranteed.

Consent of Research Participant:

Checking the box below acknowledges that:

- You authorize the MHS to use and disclose your health information for the research purposes stated above.
- You have read (or someone has read to you) the information in this Authorization.
- You have been given a chance to ask questions, and all of your questions have been answered to your satisfaction.

☐ Yes, I agree.
☐ No, I do not agree.