Form Approved
OMB No. 0920-0891
Exp. Date XX/XX/20XX

WORLD TRADE CENTER HEALTH PROGRAM

HIPAA Authorization for Youth Research Cohort

The U.S. Department of Health and Human Services (HHS), Centers for Disease Control and Prevention (CDC), National Institute for Occupational Safety and Health (NIOSH), World Trade Center (WTC) Health Program may collect or maintain protected health information regarding members of the WTC Health Program and/or participants in Program-related research.

With this authorization, I hereby give permission to HHS/CDC/NIOSH/WTC Health Program to disclose the protected health information outlined below to researchers as described below for the purposes further described.

Name of Individual to Whom this Authorization Pertains:

_____
(NAME OF INDIVIDUAL)

_____
(DATE OF BIRTH OF INDIVIDUAL)

To Whom Disclosure of Protected Health Information is Authorized:

The disclosure of personal health information will be made to approved applicants following competitive award of public health research. The award follows evaluation for scientific and technical merit through the CDC/NIOSH peer review system. Applicants seeking personal health information for awarded research are responsible for ensuring that the Project/Performance Site operates under appropriate Federal Wide Assurance for the protection of applicable research privacy and human subjects protections described in Part II of the SF 424 (R&R) Application Guide and in the HHS Grants Policy Statement.

Purpose of Disclosure of Protected Health Information:

The protected health information (PHI) will be disclosed for purposes of future youth cohort research studies. Your PHI maintained in the registry will be disclosed to researchers upon their request for the recruitment of participants in awarded research conducted under an Internal Review Board (IRB)-reviewed research protocol. Information disclosed will be the minimum necessary for the WTC Health Program to carry out its purpose, and may include (please check all that apply and describe any exclusions within each checked category):

☐*Name*
☐Sex
☐*Race and Ethnicity*
☐*Date of birth*
☐*Mailing address*
☐*Phone number*
☐*Email address*
☐*Self-reported characteristics of exposure (i.e., location, duration, and whether the exposure occurred prenatally or postnatally)*

☐*Other:* _____

Exclusions*:*

_____

_____

This authorization expires when I choose to exercise my right to revoke this authorization. I understand that I may revoke this authorization in writing at any time by sending written notification to the WTC Health Program:

ATTN: WTC Health Program Privacy Officer
400 7th Street SW, Suite 5W
Washington D.C. 20024

or by email: wtchpprivacy@cdc.gov

Use or disclosure of my protected health information by the WTC Health Program made prior to the WTC Health Program's receipt of my written request to revoke this authorization will be governed by this authorization to the extent that the WTC Health Program has taken any action in reliance on this authorization already.

Signing this authorization is voluntary. The WTC Health Program may not condition treatment, payment, enrollment, or eligibility for benefits on the signing of this authorization. The information disclosed under this authorization may be subject to further disclosure by the authorized recipient(s); such additional disclosures by third parties are not subject to, nor protected by, this authorization. The WTC Health Program will give me a copy of this signed authorization, upon request. Requests may be made in writing to the above address.

_____	_____
Printed Name of Individual	**Date of Birth**
_____	_____
Address	**WTC Health Program 911#, if applicable**
_____	_____
Address Line 2	**Phone**
_____	_____
Signature	**Date**