**HIPAA Authorization**

**Principal Investigator (PI) |** Click here to enter text.

**Department |** Click here to enter text.

**Co-Investigator(s) |** You can remove this field as necessary or enter Co-Is.

**Sponsor or Funding Source |** Click here to enter text.

**WVU IRB Protocol # |** Click here to enter text.

**Research Project Title |** Click here to enter text.

**HIPAA Authorization**

Federal and state privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA), require West Virginia University to obtain your permission before using or disclosing your protected health information for purposes of this research project.

You do not have to sign this authorization. However, if you choose not to sign the authorization, you will not be able to participate. The decision you make regarding this HIPAA Authorization will not affect your health care, enrollment in health plans, or eligibility for benefits.

**Persons/Organizations Providing the Information**

Specify as appropriate

The Patient (data are from the participant)

West Virginia University Hospitals/ WVU Medicine/ WVUHS (data are from medical records)

**Persons/Organizations Receiving the Information**

Add applicable information and/or delete any information that does not apply.

* The research site(s), including West Virginia University Health System (WVUHS), WVU Medicine, University Health Associates, and the research and medical staff.
* Health care providers who provide services to you as part of this research.
* Laboratories and other people and groups that review your health information as part of this research in compliance with the research protocol.
* If applicable, The United States Department of Health and Human Services (which includes the National Institutes of Health (NIH), Food and Drug Administration (FDA)), and other groups that have the right to use the information as required by law. ***(Required for FDA regulated research.)***
* (If applicable,) Foreign Regulatory Agencies
* (Sponsor name, if applicable) and the people and associates that may oversee manage or conduct the research.
* The members and staff of the institutional review board assigned to oversee the research.
* The West Virginia University Office of Human Research Protections and the West Virginia University Office of Sponsored Programs.
* Enter your Research Unit or Department (if applicable)

**The Following Information Will Be Used**

Specify the PHI viewed or recorded for the research and delete any sections that do not apply.

Information from your existing medical records and new information about you that is created or collected during this research, such as history and physicals, clinic visit notes, nursing and staff notes, laboratory results, x-rays, EKG results, demographic data, pulmonary tests, imaging scans, and study forms.

**The Information is Being Disclosed for the Following Reasons**

Add applicable information and/or delete any information that does not apply.

* Review of your data for quality assurance purposes
* Publication of research results (without identifying you)
* Other research purposes such as reviewing the safety or effectiveness of the study drug and other products or therapies; conducting performance reviews of the study drug; evaluating other products or therapies for patients; developing a better understanding of disease; improving the design of future clinical trials

**You may Cancel this Authorization at Any Time by Writing to the Principal Investigator**

Enter the PI name and full contact information (include a mailing address). Only written cancelation of Authorization is permissible.

If you cancel this authorization, any information that was collected cannot be withdrawn. Once information is disclosed, according to this authorization, the recipient may re-disclose it, and then the information may no longer be protected by federal regulations.

(Keep this paragraph, as appropriate) You have a right to review and make copies of your medical records. You will not be able to review or copy the records related to the research until the sponsor has completed all work related to the research. At that time, you may ask to review the records related to your participation and request corrections to the information that may be incorrect.

This authorization will expire at the end of the research unless you cancel it before that time (or has a specific expiration date).

**Signatures**

**Participant/Legally Authorized Representative (LAR) Signature**

I have read this HIPAA Authorization form describing how my protected health information will be used. I have had a chance to ask questions about the use of my protected health information and I have received answers to my questions. I agree to the use of my protected health information for this research.

| Participant/LAR Signature | | |
| --- | --- | --- |
| Printed Name |  | Date |