Bridgeport Hospital - Research Authorization Form

Subject Name: _____ **Medical Record #:** _____

Principal Investigator: _____ **IRB #:** _____

Principal Investigator's Contact Information: _____

_____

To the Subject:

We understand that information about you obtained in connection with your health care is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we wish to obtain your special authorization before we use or disclose your identifiable health information for the research purposes described below. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed. Please read the information below carefully before signing this form. If you have any questions about this authorization, please ask the Principal Investigator listed above before signing this form.

Specific Understandings

By signing this research authorization form, you authorize the use and/or disclosure of the information described below, for this research study. In accordance with HIPAA regulations, this authorization granted for research can include current and future research. The anticipated timeframe for use of your identifiable health information is disclosed below. The purpose for the uses and disclosures of your information and timeframe for the uses and disclosures that you are authorizing is [insert brief description of study]:_____

_____

_____

[as outlined in the informed consent] and to ensure that the information relating to that research is available to all parties who may need it for research purposes.

All health care providers subject to HIPAA are required to protect the privacy of your information. Your information may be redisclosed if the recipient(s) described on this form are not required by law to protect the privacy of the information.

You have a right to refuse to sign this authorization. Your health care outside the study, the payment for your health care, and your health care benefits will not be affected if you do not sign this form, but you will not be able to enroll in the research study described in this authorization and will not receive treatment as a study participant if you do not sign this form.

If you sign this authorization, you may change your mind at any time, but the researchers may continue to use information collected before you changed your mind to complete the research.

This authorization will never expire unless and until you change your mind and revoke it. To revoke this authorization, please write to the Medical Records Department at Bridgeport Hospital, 267 Grant Street, Bridgeport, CT 06610.

[**Optional** (only for research that includes treatment as part of the protocol): You will not be allowed to see or copy the portion of your medical records that describe a research treatment until the research is completed, but you may see and copy the research treatment information at the end of the research in accordance with institutional medical record policies.]

You have a right to receive a copy of this form after you have signed it. If after you have signed this form you have any questions relating to your rights, please contact the Office of Privacy and Compliance at (203) 384-3971.

Use and Disclosure Covered by this Authorization

Who will disclose, receive, and/or use the information?

The following person(s), class(es) of persons, and/or organization(s) may share, use, and receive the information listed below in connection with this Study. These persons are authorized to use and disclose the information to the other parties on this list, to you or your personal representative, or as permitted by law.

q The following health care facilities or research site(s) and research staff involved in this study:

_____ _____ _____

q Health care providers who provide services to you in connection with this study.

q Laboratories and other individuals and organizations that analyze your health information in connection with this study, in accordance with the study's protocol.

q The following research sponsors:

_____

q The United States Food and Drug Administration

q The members and staff of the Human Investigation Committee(s) or Institutional Review Board(s) that approves this study.

q Investigator and other Investigators: _____

q Study Coordinator: _____

q Additional members of the Research Team: _____

_____

Contract Research Organization (Name) _____

q Data and Safety Monitoring Boards and others authorized to monitor the conduct of the Study:

q Others (as described below)

What personal health information will be used or disclosed?

The following information about you may be used and disclosed:

q Research study records.

q Medical and laboratory records of only those services provided in connection with this Study.

q The entire research record and any medical records held by [Institution] created from: _____ to: _____

q The entire research record and any medical records can be used by [Institution] from: _____ to: _____

_____

_____

_____

Signature

I have read this Research Authorization form and all of my questions about this form have been answered. By signing below, I authorize the described uses and disclosures of information.

_____

Signature of Subject or Personal Representative

_____

Print Name of Subject or Personal Representative

_____

Date

_____

Description of Personal Representative's Authority

Contact Information

The contact information of the subject or personal representative who signed this form should be filled in below.

Address:

_____

_____

_____

_____

Telephone:

_____ (daytime)

_____ (evening)

Email Address (optional):

_____

THE SUBJECT OR HIS OR HER PERSONAL REPRESENTATIVE MUST BE PROVIDED WITH A COPY OF THIS FORM AFTER IT HAS BEEN SIGNED.