****

**REQUEST AND AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION FOR THE PURPOSE OF RESEARCH**

Cook County Health (CCH) is required to get your written permission to use or disclose (share) your health information in order for you to take part in this research study.

| PROTOCOL TITLE |
| --- |
| Principal Investigator Last Name | Principal Investigator First Name |
| IRB # | Form Version Date |

| RESEARCH SUBJECT INFORMATION (You may apply a patient label.) |
| --- |
| Last Name | First Name | Middle Name |
| **Birth Date** | **Month** | **Day** | **Year** | **Today’s Date** | **Month** | **Day** | **Year** |
| **Address** | **City** | **State** | **Zip** | **Phone** |

1. **What is the PURPOSE OF THIS FORM?** Researchers would like to use your health information to perform a study. This information may include data that identifies you. Please carefully review the information below and if you agree that the researchers and others identified below may use your health information in the ways indicated on this form, please sign and date this form.
2. **How will I be identified in this research?**

[Be specific – check one of the boxes below or write text describing the method]

☐A code will be made up combining elements of my name and date of birth

☐My medical record number will be used

☐A random number will be assigned to me and the only person with access to the list that links me to that number is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐Other, be specific \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **What INFORMATION do the researchers want to use?** The following information will be used for this research study:

[List data – as specific as possible]

[After listing the data, FOR THE BELOW – limit the check boxes to the Specific Information needed for this research]

**SPECIFIC CONSENT**

**The researcher has indicated the information that is needed by placing a check mark in the box next to the type of information. Your provider has discussed this information with you.**

**Instructions. By initialing any of the boxes next to a kind of specially protected information, I specifically Authorize the use and disclosure of the related information indicated next to the box in the manner described in this Authorization.**

|  |  |  |
| --- | --- | --- |
| **Information Requiring Specific Consent** | ***Researcher*** ***Check indicates “Required for this Study”*** | ***Research Subject* *Initials indicate Consent*** |
| Information about a Mental Illness or Developmental Disability |  |  |
| Psychotherapy Notes (which are not part of the official medical record) |  |  |
| Information about HIV/AIDS Testing or Treatment (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of these tests were positive or negative) |  |  |
| Information about Communicable Diseases |  |  |
| Information about Sexually Transmitted Infections |  |  |
| Information about Substance (i.e. alcohol or drug) Use Disorder or Abuse |  |  |
| Information about Abuse of an Adult with a Disability |  |  |
| Information about Sexual Assault |  |  |
| Information about Child Abuse and Neglect |  |  |
| Information about Genetic Testing |  |  |
| Information about Artificial Insemination |  |  |

1. **WHO will be able to use my information?**

[List – as specific as possible]

1. **Why do researchers want my information?**

[Answer – as specific as possible]

1. **How will information about me be kept PRIVATE?**
	1. The information you permit us to use and share will be transmitted in a secure way. It will be password protected and encrypted. Encryption is a process that converts the information on a computer into a format that cannot be easily understood by unauthorized people.
	2. The information you permit us to use and share as well as the research information for this study will be stored in a secure manner. Paper information is stored in a locked cabinet in a locked office with limited access. Information stored on a computer will be encrypted and accessed only by the persons listed in #4 above.
	3. The researchers will keep your information private to the extent possible. Only those listed in #4 above will have access to your information. Your information will not be released to others unless required by law.
2. **What if I DO NOT SIGN this form?** If you do not sign this Authorization, you will not be able to take part in the research study for which you are being considered, however, Cook County Health, will still take care of you.
3. **May I REVIEW my medical information or the information used or disclosed (shared) as part of this Authorization?** You may review your medical record. You will be told if viewing the record will make the research design invalid. In that case, if you choose to review your record before the study ends, you will be withdrawn from the study.
4. **What if I want to WITHDRAW my permission?** You can change your mind at any time and withdraw your permission (called, “revoke” or “revocation”) to allow your protected health information to be used in the research. If this happens, you must withdraw your permission in writing. Beginning on the date you withdraw your permission, no new health information will be used for research. This will not affect any actions taken by CCH before receiving your revocation. Your withdrawal will be acknowledged by mail unless you request otherwise.

To withdraw your permission, please contact the person below. S/He will make sure your written request to withdraw your permission is processed promptly.

 [PI Name]

 [PI Address]

 [PI Phone]

 [PI Fax]

1. **How LONG will my permission last?** Your participation and the length of participation are described in the Consent Form. This Authorization will remain in effect until the research project is over or you withdraw your permission. Data will not be taken from your medical record once your participation, as defined in the Consent Form, is complete.

| * **I understand that I may revoke this Authorization at any time by notifying CCH in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by CCH before receiving my revocation.**
* **I understand that I may refuse to sign this Authorization and that I will continue to receive my care and treatment at Cook County Health.**
* **I understand that CCH may require me to sign an authorization prior to receiving research-related treatment or treatment solely for the purpose of creating health information for another party and that CCH will not provide such research-related treatment unless I provide this Authorization.**
* **I understand that I have the right to inspect or copy any information used/disclosed under this Authorization unless it invalidates the research.**
* **I understand that once my health information is disclosed to the recipient, CCH cannot guarantee that the recipient will not re-disclose the health information to a third party or as required by law. The third party may not be required to comply with this Authorization or privacy laws.**
* **I have read and understand the terms of this Authorization and I have had a chance to ask questions about the use and disclosure of the health information. I authorize CCH to use or disclose my health information in the manner described in this Authorization.**
 |
| --- |
|  |  |
| **Signature of Research Subject**  | **Date** |
| **FOR PERSONAL REPRESENTATIVES OF THE RESEARCH SUBJECT** |
| **Name of Personal Representative** | **Relationship to Patient** |
| ***I hereby certify that I have the legal authority under applicable law to make this request on behalf of the patient identified above.*** |
|  |  |
| **Signature of Personal Representative**  | **Date** |
|  |

|  |  |
| --- | --- |
| **Printed Name of Person Obtaining Authorization**  | **Title of Person Obtaining Authorization** |
|  |  |
| **Signature of Person Obtaining Authorization**  | **Date** |
|  |

***Provide a copy of signed Authorization to Research Subject.***