Department of Veterans Affairs	**Authorization for Release of Identifiable Health Information for Research**

Study Title:

Purpose of Study:

Principal Investigator (PI):

PI Contact Information:

VA Facility (Name and Address)**:**

Subject Name (Last, First, Middle Initial)**:**

Social Security Number:

SUBJECT REQUEST: I request and authorize the Principal Investigator and research team to access, use and disclose my information as necessary and relevant for this research study. This authorization is necessary to participate in this study; however, my VHA treatment, payment, enrollment, or eligibility for benefits is not dependent upon my signing this authorization. I understand that the information to be collected includes:

☐ Drug Abuse ☐ Testing for or Infection with Human Immunodeficiency Virus (HIV)
☐ Alcoholism or Alcohol Abuse ☐ Sickle Cell Anemia
☐ Past and Present Medical Information ☐ Demographic Information
☐ Diagnostic/Laboratory/Pathology ☐ Mental Health Information
☐ Imaging (Radiology) ☐ Billing or Financial Records
☐ Photographs, videotapes ☐ Questionnaire/Survey/Subject Diary
☐ Other: _____
_____
_____

DISCLOSURE: The research team may also need to disclose the information to others as part of this study process. The VHA complies with the requirements of the Health Insurance Portability and Accountability Act of 1996, Privacy Act of 1974, and all other applicable federal laws and regulations that protect your privacy. Our Notice of Privacy Practices (a separate document) provides more information on how we protect your information. If you do not have a copy of the Notice, the research team will provide one to you. Once information is disclosed outside VHA pursuant to this authorization, it may no longer be protected by Federal laws and regulations and may be subject to re-disclosure by the recipient.

☐ Institutional Review Board (IRB) who will monitor the study
☐ VA/VHA oversight and other agency research regulators, such as Office of Human Research Protection (OHRP), Research and Development Committee, VA Office of Inspector General, Food and Drug Administration (FDA) and other authorized entities
☐ Study Sponsor: _____
☐ Academic Affiliate: _____
☐ Compliance and Safety Monitors: _____
☐ Other: _____
☐ Other: _____
☐ Other: _____

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it.

REVOCATION: I may revoke this authorization in writing, at any time except to the extent that action had already been taken to comply with it. Upon revocation, you will not be able to continue to participate in the study. Information collected prior to the revocation will continue to be used by the research team. Written revocation is effective upon receipt by the Principal Investigator.

EXPIRATION: Without my express revocation, the authorization will automatically expire:

☐ At the end of this research study
☐ Not expire. (Creation of a research database or research repository)
☐ Expire on _____

☐ While this study is being conducted, you will not be allowed to see research-related medical records that are created or obtained by the research team. You will be able to see them again when the study is complete. This will not affect your doctor's ability to see your records as part of your normal health care.

Research Subject Signature. This authorization has been explained to me and I have been given the opportunity to ask questions. If you believe that your privacy rights have been compromised, you may contact the facility Privacy Officer to file a formal complaint.

I authorize the use of my identifiable information as described in this form.

_____ _____
Signature of Participant Date

_____ _____
Signature of Legal Representative (if applicable) Date
To Sign for Participant (Attach authority to sign: Health Care Power of Attorney or Legal Guardian appointment)

_____ _____
Name of Legal Representative (please print) Date