**HIPAA Authorization to Use and Disclose Protected Health Information for Research Purposes**

**Title of Study:**

**Principal Investigator:**

**Investigator’s Contact Information:**

HIPAA is the Health Insurance Portability and Accountability Act of 1996/2003, a federal law related to privacy of health information.

**What is the purpose of this form?**

You have been asked to take part in a research study. The consent form for this study describes your participation and all that information still applies. The purpose of this form is to obtain your permission to use health information about you that is created by or used in conjunction with this research.

**What if I don’t want my personal health information (PHI) to be used in a research study?**

You do not have to give this permission. Your decision to sign this form will not change your ability to get health care outside of this research study. However, if you do not sign this form you will not be allowed to participate in the study.

**What PHI am I allowing to be used for this research?**

[investigator insert specifics]

[HIPAA requires a specific and meaningful description of the information you will collect or obtain about participants. This should be as specific as possible but should also be broad enough to cover all information that may be needed during the study.]

**Where will the researchers go to find my PHI?**

Researcher modify as appropriate [We may ask you for specific medical and mental health details in our questionnaires. We may ask to see your personal information in records at hospitals, clinics or doctor’s offices where you may have received care in the past, including but not limited to facilities in the Florida Tech system (such as the Scott Center for Autism Treatment).]

**Who will be allowed to see my PHI?**

The researcher named above and staff members of this research team will be allowed to see and use your health information for the research study. Your records may also be viewed by representatives of Florida Tech’s IRB for the purposes of oversight and participant safety and compliance with human research regulations.

**Will my information be used in any other way?**

Your information used under this permission may be subject to re-disclosure outside of the research study and be no longer protected under certain circumstance such as required reporting of abuse or neglect, required reporting for law enforcement purposes, and for health oversight activities and public health purposes.

**What if I can change my mind after I give this permission?**

You can change your mind and withdraw this permission at any time by informing the Principal Investigator. If you withdraw this permission, the researcher may only use and share your information that has already been collected for this study. No other additional health information about you will be collected by or given to the researcher for the purposes of this study.

**What are the privacy protections for my PHI used in this research study?**

HIPAA regulations apply to personal health information in the records of health care providers and other groups that share such information. There are some differences in how these regulations apply to research, as opposed to regular health care. One difference is that you may not be able to look at your own records that related to this research study. These records may include your medical record, which you may not be able to look at until the study is over.

**How long does this permission allow my PHI to be used?**

If you decide to be in this research study, your permission to access and use your health information in this study may not expire, unless you revoke or cancel it. Otherwise, we will use your information for as long as it is needed for the duration of the study.

I am the research participant or the personal representative authorized to act on behalf of the participant. By signing this form, I am giving permission for my personal health information to be used in research as described above. I will be given a copy of this authorization form after I have signed it.

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| --- | --- | --- |
| Name of Research Participant | Signature | Date |
|  |  |  |
| Name of Researcher | Signature | Date |