Protocol Title:

Principal Investigator Name:

Version Date:

IRB #:

HIPAA Compliant Research Authorization Form

Florida Institute of Technology

Researchers at Florida Institute of Technology are required to get written permission to use health information from the people taking part in a research study. This permission is called an “Authorization.” In order to take part in this research study you must sign this Authorization form.

**A. How will my health information be used?**

Your health information will be used to:

**B. What information will be used?**

The following information about your health will be used for this research study*:*

**C. Who will use my health information?**

The people who hold your medical records will share your health information with the researchers, who may also share with other people outside the university. (If your health information will be shared outside Florida Tech, those outside institutions and researchers receiving your health information will be listed below.)

1. Record Holders:

2. Researchers and Others:

***D.* How long will my permission last?**

This Authorization does not have an end date. You can end this Authorization at any time, however, by withdrawing your permission in writing. Beginning on the date your permission ends, no new health information will be used. Any health information that was shared before you withdrew your permission will continue to be used. After this Authorization ends, you can no longer actively take part in this research study.

**E. Is my permission voluntary?**

Your permission is voluntary. You do not have to sign this Authorization form and you may refuse to do so. Your health care providers must continue to provide you with health care services even if you refuse to sign this Authorization form. If you refuse to sign this form, however, you cannot take part in this research study.

**F. How will my health information be protected?**

Whenever possible your health information will be kept confidential. Federal privacy laws may not apply, however, to some people outside of Florida Tech who can share your health information without your permission. If you signed a consent form to take part in this research, more information about confidentiality protections may be found there.

**G. Additional information.**

You should take as much time as you need to make your decision about giving permission for the use of your health information for this research study. Please ask any questions you have about this Authorization form.

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

Signature of individual or personal representative:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*YOU SHOULD RECEIVE A COPY OF THIS FORM AFTER SIGNING IT\*\*

If this Authorization form is signed by a personal representative, please print his or her name and relationship to the individual:

Name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of person obtaining Authorization:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_