Appendix G
Authorization (Permission) to Use or Disclose (Release) Identifiable Health Information for Research

LANGSTON UNIVERSITY
INSTITUTIONAL REVIEW BOARD

Authorization (Permission) to Use or Disclose (Release) Identifiable Health Information for Research

Title of Study:_____

Name of Investigator:_____

What is the purpose of this form?
Researchers would like to use your health information for research. This information includes data that identifies you. If you sign this document, you give permission to ***[Name (or class of persons or organizations) who may use or disclose health information for the study {covered entity}.]*** to use or disclose (release) your health information that identifies you for the research study described below:

[Provide description of the research study, such as the title and purpose of the research.]

What personal health information will be used or disclosed?
The health information that may be used or disclosed for the research includes:

[Provide a description of information to be used or disclosed for the research project. This may include for example, all information in your medical record, results of physical examinations, medical history, lab tests, or certain health information indicating or relating to a particular condition.].

Who can receive my health information for this purpose?
The health information listed above may be used and/or disclosed (released) to:
[List ALL names or other identification, or All classes of persons who will have access to the PHI (e.g. research collaborators, sponsors, data coordination center, and oversight agencies, IRBs)]

How will information about me be kept private?

[Covered entity] is required by law to protect your health information. By signing this document, you authorize ***[covered entity]*** to use and/or disclose (release) your health information for this research. Those persons who receive your health information may not be required by Federal privacy laws (such as the

Privacy Rule) to protect it and may share your information with others without your permission, if permitted by laws governing them.

What happens if I do not sign this permission form?
Please note that ***[covered entity]*** may not condition (withhold or refuse) treating you on whether you sign the Authorization. .

What happens if I change my mind?
Please note that you may change your mind and revoke (take back) this Authorization at any time, except to the extent that it has already been acted upon. Even if you revoke this Authorization, health information already obtained about you may be used or disclosed as necessary to maintain the integrity or reliability of the current research. To revoke this Authorization, you must contact ***[insert contact name and information to include both phone number and mailing address]***.

How long will this permission last?
This Authorization ***[insert expiration date or event, such as "end of research study."]***

_____	_____
Signature of participant or participant's personal representative	Date
_____	_____
Printed name of participant or participant's personal representative	If applicable, description of the personal representative's authority to sign for participant