AUTHORIZATION TO DISCLOSE HEALTH INFORMATION FOR RESEARCH

IRB Study #_____ Title of Study_____

Client Name_____ Date of Birth _____

Client Record #_____ Client SS # *(Optional)*_____

I_____ hereby authorize
(Client or Personal Representative)

_____ to disclose specific health information
(Name of Health Care Provider/Plan)

from the records of the above-named client to: _____
(Principal Investigator Name/Address/Phone/Fax)

for the specific research study: _____
(Description of Research Study)

Specific information to be disclosed: _____

I understand my health information will be used and disclosed to those who are authorized to conduct the research, and it may also be disclosed to authorized third parties such as representatives of the research sponsor, an institutional review board, and representatives of government agencies, including the Food and Drug Administration (FDA) or the Office of Human Research Protections, to review the research and for the following purposes: _____

I understand that this authorization will expire on the following date, event or condition: _____

I understand that if an expiration date or condition is not stated above, this authorization is valid for the period of time needed to complete the study or for up to one year, whichever is sooner. I also understand that I may revoke this authorization at any time and that I will be asked to sign the *Revocation Section* on the back of this form and return it to the Health Care Provider or Health Plan named above. I further understand that the principal investigator in the study may continue to use and disclose the individually identifying health information gathered prior to the rescind date if the information is needed to maintain the integrity of the research or for reporting purposes such as adverse events reporting.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations and/or NC Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS, or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information.

I also understand that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits outside this study but will result in me not being able to participate in the study.

I further understand that I will be given a copy of this signed authorization.

_____	_____	_____
(Signature of Client)	*(Date)*	*(Witness-If Required)*
_____	_____	_____
(Signature of Personal Representative)	*(Date)*	*(Personal Representative Relationship/Authority)*

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NOTE: This Authorization was revoked on _____ _____
(Date) *(Signature of Staff)*

REVOCATION SECTION

I do hereby request that this authorization to disclose health information of _____
(Name of Client)

signed by _____ on _____
(*Enter Name of Person Who Signed Authorization)* *(Enter Date of Signature)*

be rescinded, effective _____ I understand that the principal investigator in the study may continue to use
(Date)
and disclose my individually identifying health information that was gathered prior to the rescinded date according to the original terms of this authorization if the information is needed to maintain the integrity of the research or for reporting purposes.

_____	_____	_____	_____
(Signature of Client)	*(Date)*	*(Signature of Witness-if required)*	*(Date)*

_____	_____	_____
(Signature of Personal Representative)	*(Date)*	*(Personal Representative Relationship/Authority)*