**AUTHORIZATION TO USE AND DISCLOSE PROTECTED**

**HEALTH INFORMATION FOR RESEARCH PURPOSES**

Ascension Wisconsin, including the sites of Affinity Health System, Ministry Healthcare, Columbia St. Mary’s and Wheaton Franciscan Healthcare, is dedicated to protecting the privacy rights of patients. Any uses and disclosures of personal health information are in accordance with a law called the Health Insurance Portability and Accountability Act of 1996 as amended by the Health Information Technology for Economic and Clinical Health Act (“HIPAA”). HIPAA is designed to protect the confidentiality of your health information. This document explains how your health information will be used and disclosed for the purposes of conducting, monitoring and auditing this study and describes your rights with respect to that information.

Your personal health information is information about you that could be used to identify you, such as your name, address, telephone number, photograph, date of birth, social security number, new and existing medical records, DNA samples, or the types, dates and results of various tests and procedures. This may include information in your medical and hospital records, as well as information created or collected during the study.

By signing this document you authorize the study physicians and Ascension Wisconsin and employees (collectively and individually “Researchers”) to use and disclose the following information about you to each other, the study sponsor and its representatives, research partners, the Institutional Review Board, and governmental agencies responsible for the oversight of this study, including the Food and Drug Administration and any foreign agencies as necessary: personal health information in your medical and hospital record including medical/surgical history, past and current medications, vital signs, physical examinations and laboratory results, other assessments, photographs and samples and analyses of blood, DNA and/or wounds. Your personal health information will be used to conduct the research study as described in the Informed Consent.

If results of this study or future research you have authorized are published or reported in medical journals or at meetings, your name will not be included.

You will not be allowed to review the information collected for the study until after the study is completed. When the study is over you will have access to the information again. Ascension Wisconsin will not condition treatment or payment on whether or not you sign this document. However, this document is required if you want to participate in the study.

Your authorization to disclose your personal health information in connection with the study will expire at the end of the study and after all study-related data has been transferred to the sponsor. You may revoke your authorization to use your personal health information for the study in writing at any time by writing to the Ascension Wisconsin IRB Office at 400 W Riverwoods Pkwy, Glendale, WI 53212. You understand that if Ascension Wisconsin has already taken action in reliance on your authorization they do not have to undo that action. If you revoke your authorization to use and disclose personal health information in connection with the study, you will no longer be able to participate in the study.

Once information is disclosed, it can no longer be controlled by the study physician, Ascension Wisconsin or by you and may be re-disclosed by the recipient. Thus, your information would no longer be protected by HIPAA.

A copy of this document will be placed in your medical record and you will receive a copy.

By signing this document, you acknowledge that you have read and understand this Authorization. Further, you authorize the Researchers to use or disclose your health information in accordance with the terms of this Authorization.

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| **Title of Study:** enter title  **Sponsor:** enter sponsor name | **IRB#** enter IRB #  NCT # enter NCT #, if applicable |
| Printed name of subject  Signature of subject/ legally authorized representative (LAR) Date  *If LAR, relationship of LAR to subject:* | |