Study Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WITHDRAWL FROM RESEARCH PARTICIPATION AND REVOCATION OF HIPAA AUTHORIZATION**

Dear Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

Effective \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_, I would like to (*please choose one of the following options*):

[ ] **Withdraw from the study referenced above and revoke HIPAA Authorization**

I revoke my authorization to use and/or disclose my future personal health information.

*(In rare instances, the research team may need to use your information even after you revoke your authorization, for example, to notify you of any safety concerns.)*

[ ] **Withdraw from the study referenced above, but continue HIPAA Authorization**

I allow the research team to continue collecting personal health information from my medical chart.

*(This would be done only as needed to support the goals of the study and would not be used for purposes other than those already discussed in the research consent and authorization form.)*

I understand that health information already collected as part of this study will continue to be used and/or disclosed as described in the research consent and HIPAA authorization form, which I signed when enrolling into the study.

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Signature of Study Participant Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Study Participant

*Optional*:

I am withdrawing from the study referenced above because:

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***For Completion by Study Team Only***

Signature of Person Receiving Withdrawl Printed Name Date Received

Signature of Principal Investigator Printed Name Date Acknowledged