

- 1. History and Physical Exam _____
 - 2. Hospital Inpatient Records _____
 - 3. Clinic/Outpatient Records _____
 - 4. Consultation Reports _____
 - 5. Laboratory Test Results _____
 - 6. Radiology Reports _____
 - 7. Pathology Reports _____
 - 8. Discharge Summary _____
 - 9. Progress Notes _____
 - 10. Photographs, Videotapes _____
 - 11. X-Ray Films/Images, Digital or Other Images _____
 - 12. Diagnosis and Treatment Codes _____
 - 13. Complete Billing Record _____
 - 14. Other (specify) _____
- _____
- _____
- _____

I understand that copies of the records indicated above will be:

- Used by employees of LSUHSC-NO including treatment providers, and/or other members of its workforce.
- Disclosed to government officials or government agencies, study sponsors, study monitors, or others responsible for oversight of the research project.
- Sent to collaborating researchers outside LSUHSC-NO if and to the extent indicated in the attached Informed Consent document(s).

I understand that by signing this form, I will allow LSUHSC-NO and its researchers to use or disclose my health information in connection with the attached Informed Consent and for the purpose of the research that is described in the Informed Consent. For example, the researchers may need the information to verify that I am eligible to participate in the study, or to monitor the results, including expected or unexpected side effects or outcomes. Other University and government officials, safety monitors, and study sponsors may need the information to ensure that the study is conducted properly. Also, I understand that my health information may be disclosed to insurance companies or others responsible for my medical bills in order to secure payment.

I understand that any privacy rights not specifically mentioned in this Authorization are contained in the Notice of Privacy Practices that I received or will receive from the Principal Investigator or at the facility that I attend.

I understand that I may revoke this authorization at any time, except to the extent that LSUHSC-NO has already relied on the authorization, by sending or transmitting of a facsimile, a written notice to the contact person listed in the attached Informed Consent document(s).

I understand that if my information already has been included in a research database or registry as described in the attached Informed Consent document(s), LSUHSC-NO considers itself to have relied on it and, therefore, my information will not be removed from those repositories.

Unless otherwise revoked, I understand that this authorization:

- Will not expire or
- Will expire upon _____
Enter date or event

I understand that if I do not sign this form, I will not be able to participate in the above research study or receive the study-related interventions, but that LSUHSC-NO cannot otherwise condition treatment on my signing this form.

While the research study is in progress, my right to access any research records or results that are maintained by the facility may be suspended until the research study is over. If my access is denied, I understand that it will be reinstated at the end of the research study.

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act. The LSUHSC facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I understand that this authorization supersedes any contrary information in any other documents I have signed related to the attached study.

Signature of Patient or Patient's Legal Representative

Date

Printed Name of Legal Representative (if any)

Representative's Authority to Act for Patient (e.g., relationship to patient)

Verification of Representative's Authority

- Viewed driver's license
- Viewed Power of Attorney
- Viewed other (specify) _____