LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER NEW ORLEANS (LSUHSC-NO)

and CHILDREN’S HOSPITAL

**INSTITUTIONAL REVIEW BOARDS**

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**AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

**FOR RESEARCH PURPOSES**

(Instructions for Investigators: This form must be reviewed and signed by patients participating in research/clinical trials that require a signed Informed Consent. These documents should be kept together. A copy of this Authorization and the Informed Consent must be given to the patient and/or his/her representative.)

## Title of Research Project: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Sponsor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ LSU IRB Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Principal Investigator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CH IRB Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I hereby request and authorize the LSUHSC-NO and/or Children’s Hospital to use and disclose protected health information from the record(s) of:

## Patient’s Name/Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Birth Date:** **\_\_\_\_/\_\_\_\_/\_\_\_\_**

Specifically, I request and authorize any part of my health information relevant to the research project, identified above and in the Informed Consent document, to be used and/or disclosed to the Principal Investigator identified above or his/her designee, in connection with the research project. (NOTE: The following sentence may be deleted if not appropriate): I understand that this may include information relating to: Human Immunodeficiency Virus (“HIV”) infection or Acquired Immunodeficiency Syndrome (“AIDS”); treatment for or history of drug or alcohol abuse; and/or mental or behavioral health or psychiatric care.

I specifically authorize the use and disclosure of the following PHI:

(Please provide a detailed description of the particular data and period of time you are requesting)

\_\_\_\_\_\_Complete health record(s) for date(s) of service from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, which may contain all of the documents listed below, as well as other notes or documents relating to my treatment or hospitalization.

\_\_\_\_\_\_History and physical exam\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_Hospital Inpatient Records\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_Clinic/Outpatient Records\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Consultation reports \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_Laboratory test results\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_Radiology Reports\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_Pathology Reports\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_Discharge Summary\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_Progress Notes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_Photographs, videotapes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_X-Ray films/images, digital or other images\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_Diagnosis and Treatment Codes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_Complete billing record\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

I understand that by signing this form, I am allowing LSUHSC-NO and/or Children’s Hospital and their 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/Hospital 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 and/or Children’s Hospital 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 and/or Children’s Hospital 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 {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 and/or Children’s Hospital 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 and/or Children’s Hospital facilities, their 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)