

**UNIVERSITY OF NEW MEXICO
MAIN CAMPUS INSTITUTIONAL REVIEW BOARD
HIPAA¹ AUTHORIZATION TO USE AND DISCLOSE
INDIVIDUAL HEALTH INFORMATION FOR RESEARCH PURPOSES**

1. **Authorization.** As a research participant, you authorize [Enter Name of PI] and the researcher's staff to use and disclose your individual health information for the purpose of conducting the research project entitled [title of study].
2. **Information to be Use or Disclosed.** Your individual health information that may be used or disclosed to conduct the study includes: [List all individual health information to be collected for the study, such as results of physical examinations, blood tests, x-rays, demographic information, and other diagnostic and medical procedures as well as medical history].
3. **Parties Authorized to Disclose Information.** The researcher and the researcher's staff may obtain your individual health information from [List all hospitals, clinics, other providers, and health plans from which you will request individual health information about the research participants to conduct the study, OR leave the space open for the patient to fill in as appropriate].
4. **Parties Who May Receive or Use Information.** Your individual health information disclosed by parties listed in item three and information disclosed by you or discovered about you during the course of the research may be received and used by [Enter name of PI] and the researcher's staff and [list any collaborators, other clinical sites engaged in the research, sponsors if any, outside laboratories and any other person or entity to whom disclosure of personal health information is likely].
5. **Right to Refuse to Sign this Authorization.** You understand that you do not have to sign this Authorization. If you do not sign, then you will not be allowed to participate in the study or receive any treatment that may be provided through the study. However, your decision not to sign this Authorization will not affect any other treatment, payment, or enrollment in health plans or eligibility for benefits.
6. **Right to Withdraw Authorization.** You understand you can change your mind and withdraw this Authorization at any time by sending a written notice to [Insert name of PI and address] to inform the researcher of your decision. If you withdraw this Authorization, the researcher may only use and disclose individual health information already collected for the study. No additional health information about you will be collected by or disclosed to the researcher for the study.
7. **Potential Re-disclosure.** Your individual health information disclosed under this Authorization may be subject to re-disclosure outside the research study and no longer protected under certain circumstances such as mandated reporting of abuse or neglect, required disclosures for law enforcement purposes, and for health oversight activities and public health purposes.
8. **Suspension of Access to Health Records.** You understand that you may not be allowed to review information collected about you for this study, including information recorded in your medical record, until the study is completed. When the study is over you will have the same rights to access the information as you had before enrolling in the study.
9. **Expiration of Authorization.** [Select ONE of the following statements appropriate for this study]: This authorization will expire [date]. This authorization will expire upon completion of the study. This authorization does not have an expiration date.

¹ HIPAA is the Health Insurance Portability and Accountability Act of 1996, a federal law related to privacy of health information.

I am the research participant or the personal representative authorized to act on behalf of the participant. I have read this information, and I understand I will receive a copy of this Authorization when it has been signed.

Name of Subject (type or print)

Name of Legal Representative
(Legal guardian, authorized surrogate under Uniform Health Care Decisions Act)

Describe authority of personal representative to act on behalf of the research subject

Signature of Subject or Legal Representative

Date