This is a sample of a consent form that is used in conducting research with living subjects in certain types of mental and physical healthcare environments. You may modify this form to meet your specific needs.

GUIDELINES FOR SUBJECT AUTHORIZATION FORM FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) FOR RESEARCH

This form must be in a language easily understood by the subject. Avoid technical terms or explain thoroughly in simple lay language if they must be used. The form should represent the subject's statement in his/her own words since he/she will sign it. The forms should be titled "Authorization Form for Use and Disclosure of Protected Health Information for Research" and contain the elements required for an authorization form as designated by the Office for Civil Rights. The legality of the subject's signature is the responsibility of the principal investigator. (The following elements must be titled and addressed separately.)

(This paragraph must be used verbatim following the project title.)
The United States government has issued a new privacy rule to protect the privacy rights of individuals enrolled in research. The Privacy Rule is designed to protect the confidentiality of an individual’s health information. This document hereafter known as an “Authorization for Use and Disclosure of Protected Health Information for Research” describes your rights and explains how your health information will be used and disclosed for this study.

PURPOSE
You are being invited to participate voluntarily in the above-titled research project. The purpose of this project is (state specifically why the study is being proposed). (A description that relates to the need for medical information is acceptable.)

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
Provide a description of information to be used or disclosed and include reason why the information is needed for the study (access should be limited to minimum amount of information necessary to attain study goals). State how long the information will be linked to the subject's identifying information. The information should be understandable to the individual, not merely a list of elements understandable only to the research team. Terms such as lab tests, clinic visit information, X-ray reports are appropriate. Avoid other unnecessary medical jargon. This information will be used for (describe how the information will be used.) Indicate who is providing the information (list the person/organization providing the information) to (list the person/organization receiving the information). You have the right to access your PHI that may be created during this study as it relates to your treatment or payment. Your access to this information will become available only after the study analyses are complete. (If the research subject's access rights are to be suspended while the study is in progress, the authorization form must include an agreement to this denial of access and that the right to access PHI will be reinstated at the conclusion of the study.)

CONTACTS (Include the following sentences)
You can obtain further information from the Principal Investigator ___________ (name of Principal Investigator plus his/her degree, M.D., Ph.D., Pharm.D., Ph.D. Candidate, etc) at ( ) __-____. If you have questions concerning your rights as a research subject, you may call the Human Subjects Committee Chairperson at ( ) ____-_____.

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AUTHORIZATION
I hereby authorize the use or disclosure of my individually identifiable health information. I may withdraw this authorization at any time by notifying the Principal Investigator in writing. The address for the Principal Investigator is (insert address here.) If I do withdraw my authorization, any information previously disclosed cannot be withdrawn and may continue to be used. Once information about me is disclosed in accordance with this authorization, the individual or organization that receives this may redisclose it and my information may no longer be protected by Federal Privacy Regulations. I may refuse to sign this authorization form. If I choose not to sign this form, I cannot participate in the research study. Refusing to sign will not affect my present or future medical care and will not cause any loss of benefits to which I am otherwise entitled. This authorization will expire on the date the research study ends. (Other options include actual date of expiration, occurrence of a particular event, or “none”, [meaning the authorization will have no expiration date].) I will be given a copy of this signed authorization form.

_________________________________________
Subject’s Signature        Date

_________________________________________
Printed Name of Subject

_________________________________________
Signature of Subject’s Legal Representative (if necessary)        Date

_________________________________________
Printed Name of Subject’s Legal Representative

_________________________________________
Relationship to the Subject

Revised: 2/5/07