# ORI Logo

# Institutional REview Board

# Authorization to Use or Disclose (Release) PROTECTED Health Information in Research Form

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| **AUTHORIZATION TO USE OR DISCLOSE (RELEASE) PROTECTED HEALTH INFORMATION PROCEDURE** |
| This form should be used only to obtain permission from research participants to use or disclose their protected health information. It should not be completed for studies that do not involve health information or medical procedures.   * The Project Information section of this form must be completed before being submitted for IRB approval. * Completed copies of this form must be provided to all research participants before gaining their Authorization.   Last edited: May 30th, 2023 |

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| Today’s date: | | | | Authorization Expiration Date: | | | |
| Project INformation | | | | | | | |
| Project Title: | | | | | | | Protocol #: |
| Principal Investigator: | | Phone: | | | Email: | | |
| College: Choose an item. | School and Program: | | | | | Campus Address: | |
| Covered Entity: | | | **Note: The Covered Entity is the organization or institution that will be providing health information of the patient(s), which is protected under HIPAA law, e.g. The University of Southern Mississippi.** | | | | |
| List all individuals at the Covered Entity who will be releasing research participants’ health information. | | | | | | | |
| Briefly describe the purpose and nature of the research. | | | | | | | |
| Describe the information to be used or disclosed, e.g., all information in the medical record, results of physical examinations, medical history, lab tests, or only health information related to a certain condition. | | | | | | | |
| List all individuals involved in the research who will have access to protected health information. | | | | | | | |
| PROTECTED HEALTH INFORMATION AUTHORIZATION | | | | | | | |
| The Covered Entity listed above is required by law to protect your health information. If you sign this document, you authorize the Covered Entity to use and/or disclose (release) your health information for this research. Those persons who receive your health information may not be required by Federal privacy laws (such as the Privacy Rule) to protect it and may share your information with others without your permission, if permitted by laws governing them.  If you sign this document, you give permission to the specific individuals listed above at the Covered Entity to use or disclose (release) health information that identifies you to researchers listed above for the indicated research purposes.  This Authorization expires on the expiration date listed at the top of this form.  Please note that you do not have to sign this Authorization. The Covered Entity may not withhold or refuse treatment or services based on whether you sign this Authorization. Also, if you sign, you may change your mind and revoke (take back) this Authorization at any time. Even if you revoke this Authorization, the researchers may still use or disclose health information they already have obtained about you as necessary to maintain the integrity or reliability of the current research. To revoke this Authorization, you must write to Principal Investigator using the contact information listed above.  By signing below, I acknowledge that I have read, understood, and approve of the information contained herein and authorize the use of my protected health information in research as designated above.    **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**    **Research Participant or Participant Representative**    **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Date** | | | | | | | |