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**Authorization Form For Use And Disclosure Of Protected Health Information (Phi) For Research**

**Project Title:** Click or tap here to enter text.

**Principal Investigator:** Click or tap here to enter text.

**Institution of the Principal Investigator**: Click or tap here to enter text.

# PURPOSE

State and federal privacy laws protect the use and release of your health information. The purpose of this form is to give your permission to the research team to obtain, use, or share your protected health information (PHI). This protected health information will be used to do the research named above.

This form describes the different ways that your information can be shared with the researcher, research team, and people with oversight responsibility.

This form is also used for parents to provide permission to obtain the individual health information of their minor children, and for legally authorized representatives of subjects (such as an appropriate family member) to provide permission to obtain individual health information of individuals who are not capable themselves of providing permission. In such cases, the terms “you” and “your health information” refer to the subject rather than the person providing permission.

**FROM WHOM, OR WHERE WILL YOU OBTAIN MY PROTECTED HEALTH INFORMATION?**

By signing this form you are giving permission to the organization(s) below to disclose your health information from your medical or other healthcare records. The health information disclosed may include information that can identify you.

* Click or tap here to enter text.

**WHAT INFORMATION MAY BE USED AND GIVEN TO OTHERS?**

The health information that will be obtained and used by the researchers will be for the following time period: Click or tap here to enter text..

The specific information that will be released and used for this research is described below. By law, the information must be limited to the minimum necessary needed to accomplish the purpose of the study:

* Click or tap here to enter text.

**WHO MAY USE AND RECEIVE INFORMATION ABOUT ME?**

Your protected health information may be obtained, used, or shared with these individuals or organizations for the following purposes:

1. To the research team for the research described in the Research Consent Form;
2. To others with authority to oversee the research to make sure it is done safely and correctly like compliance staff at Texas A&M University (i.e., Institutional Review Board (IRB) or Privacy Officer).
3. To others who are required by law to review the quality and safety of the research or public health authorities including: US government agencies, such as the Food and Drug Administration or the Office of Human Research Protections.
4. Sponsors or their business partners involved in the research.

**WHY WILL THIS INFORMATION BE USED AND/OR GIVEN TO OTHERS?**

The researchers will use your individual health information to achieve the purpose of the study only in the ways that are described in the research consent form that you will sign.

**HOW LONG WILL THIS INFORMATION BE USED AND/OR GIVEN TO OTHERS?**

The permission to use your PHI will continue indefinitely unless you withdraw your authorization in writing.

**MAY I REVIEW OR COPY THE INFORMATION OBTAINED FROM ME OR CREATED ABOUT ME?**

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.

**MAY I WITHDRAW OR REVOKE (CANCEL) MY PERMISSION?**

You may cancel your permission at any time by notifying the Principal Investigator in writing. If you cancel your permission you can no longer be in the research study. If you choose to cancel your permission, any information previously disclosed cannot be withdrawn and may continue to be used but no new health information identifying you will be used or shared. The address for the Principal Investigator is Click or tap here to enter text.

**WHAT IF I DECIDE NOT TO GIVE PERMISSION TO USE AND GIVE OUT MY HEALTH INFORMATION?**

You may refuse to sign this authorization form. If you choose not to sign this form, you cannot participate in the research study. Refusing to sign will not affect your present or future medical care and will not cause any loss of benefits to which you are otherwise entitled.

**IS MY HEALTH INFORMATION PROTECTED AFTER IT HAS BEEN GIVEN TO OTHERS?**

Once information about you is disclosed in accordance with this authorization, the individual or organization that receives this may redisclose it and your information may no longer be protected by Federal Privacy Regulations.

**CONTACTS**

You can obtain further information from the Principal Investigator, Click or tap here to enter text. by telephone at Click or tap here to enter text. or via email at Click or tap here to enter text..

If you have questions concerning your rights as a research subject, you may call the Human Subjects Protection Program office at (979) 458-4067 or via email at irb@tamu.edu.

**AUTHORIZATION**

I hereby authorize the use and disclosure of my individually identifiable health information. I will be given a copy of this signed authorization form.

**Subject**

If you agree to the use and release of your Personal Health Information, please sign below.

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Subject’s Signature Date

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Printed Name of Subject

**Parent or Legally Authorized Representative**  
If you agree to the use and release of the above named subject’s Personal Health Information please sign below.

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Signature of Subject’s Parent or Legal Representative Date

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Printed Name of Subject’s Parent or Legal Representative

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Relationship to the Subject