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|  |  | Grand Canyon University  College of Doctoral Studies  3300 W. Camelback Road  Phoenix, AZ 85017  Phone: 602-639-7804  Email: irb@gcu.edu |

HIPAA AUTHORIZATION FORM

(Example Template)

AUTHORIZATION TO COLLECT, USE, AND SHARE HEALTH INFORMATION FOR RESEARCH

By law, researchers must protect the privacy of health information about you. This form and the uploaded research consent form need to be kept together.

We are asking you to take part in the research described in the uploaded consent form. The researchers are not authorized to collect any health information about you unless that information is described in the consent form that you sign.

***What is “health information”?***

As used in this form, the phrase “health information” includes:

* Health information that identifies you.
* Information about you that is created during the research study. This might include the results of tests or exams that become part of the study records; diaries and questionnaires that you might be asked to fill out as part of the study and other records from the study.
* Information in your medical records that is needed for this research study. These might include the results of physical exams, blood tests, x-rays, diagnostic and medical procedures and your medical history.

The specific information that will be collected in this research is described in the uploaded consent form. For you to be in this research, we need your permission to collect and share this information.

***Who will see the health information collected in this research?***

If you agree to participate, you are giving permission for the researchers to share your health information with the following people and groups:

* Anyone listed in the informed consent document as a person or group that you agree may receive information about you,
* Anyone listed in a separate authorization for release of medical records or information that is signed by you,
* People at GCU who help with the research,
* People outside of GCU who are in charge of, pay for, or work with us on the research; such as, the sponsor of the study, [*sponsor’s name*], and its representatives.
* Government agencies, review boards, and others who watch over the safety, effectiveness, and conduct of the research.
* Other researchers when a review board approves the sharing of the health information.
* Your health insurer if they are paying for care provided as part of the research study.
* Others, if the law requires.

The researchers cannot control what any of these persons or groups may do with the information they receive about you and the privacy of your information may no longer be protected by federal privacy rules after it is disclosed to them.

***What if you don’t want to participate in the research?***

You do not have to sign this permission (“authorization”) form if you do not want to be in the research. If you do not sign, then you will not be allowed to participate in the study. If you decide not to sign, it will not result in any penalty or loss of benefits to which you are entitled.

If you sign this form and then change your mind later, and do not want us to use and share your health information, you will need to send a letter to the researcher at the address listed on the uploaded consent form. The letter will need to say that you have changed your mind and do not want the GCU researcher to collect and share your health information. The researcher may still use the information they have already collected.

***Will you get to see the health information collected about you?***

Depending on the nature of the research, it is possible that you will not have access to health information about you that is created during the study until after the study is complete.

If you have any questions, please contact the researcher listed on the uploaded consent form. You may also call the GCU College of Doctoral Studies at 602-639-7804 with questions about the research use of your health information. Your researcher will give you a signed copy of this form.

I agree to the collection, use, and sharing of my health information for purposes of this research study.

[Researcher should select one of the following options and delete the other:]

* This permission will expire on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(date)
* This permission will not expire unless you tell the researchers in writing that you have changed your mind and no longer want to participate.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of research subject or subject’s Date

Legal Authorized Representative (LAR)

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Printed name of research subject or subject’s Representative’s relationship to

Legal Authorized Representative (LAR) subject