**Authorization to the Use or Disclosure (Release) of Protected Health**

**Information for Research Purposes**

Information Page for Chapman Researchers

The collection and use of Protected Health Information (PHI) are governed under federal privacy rules under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). PHI is normally only collected by a “covered entity”, including hospitals, medical or health-related clinics or offices where clinical professionals provide service, private practices where clinical professionals provide service, etc. While Chapman University is not a HIPAA-covered entity, Chapman researchers may still be able to collect and use PHI (e.g., medical records, MRI reports, and results of a hearing test). One way is if the participant provides written authorization for a researcher from a non-covered entity, i.e., Chapman University, to obtain their PHI information from a HIPAA covered entity, e.g., a hospital.

Participants who sign the form (see below) are authorizing Chapman University researchers to access their (PHI) for research purposes only. By doing so, the PHI becomes a part of the research record and is subsequently governed by the terms of their signed Authorization and is no longer considered PHI subject to HIPAA regulations. Although the HIPAA Privacy Rule no longer applies to this information, the Chapman researcher will protect the confidentiality of the participant's information.

* The Authorization form should include affirmative statements that ensure the confidentiality of PHI and state how long the participant’s PHI will be kept as a part of the research record and should be included on the informed consent form (ICF).
* Participants should have the option of stating they do not wish to release their PHI to the researcher. In this case, the PI should clearly state whether PHI is a requirement of participating in the study. This information should also be clearly stated on the ICF.
* There are required statements and optional statements to include on the authorization form. Required statements are listed first, followed by optional statements to consider including depending on the research.
* Please customize the form below, filling the required information, including the PHI information that you need for your research. Examples are provided.
* Please delete this information page before uploading an unprotected version of this form into Cayuse when prompted

**Authorization to the Use or Disclosure (Release) of Protected Health**

**Information for Research Purposes**

**Chapman University**

**[REQUIRED STATEMENTS]**

If you sign this document, you give permission to [name or other identification of specific health care provider(s) or description of classes of persons, e.g., all doctors, all health care providers] at [name of covered entity or entities] to use or disclose (release) your health information that identifies you for the research study described here:

[Provide a description of the research study, including the title and purpose of the research.]

The health information that we may use or disclose (release) for this research includes

[complete as appropriate]:

[Provide a description of information to be used or disclosed for the research project. This may include, for example, all information in a medical record, results of physical examinations, medical history, lab tests, or certain health information indicating or relating to a particular condition.]

The health information listed above may be used by and/or disclosed (released) to:

[Name or class of persons involved in the research; i.e., researchers and their staff]

[Name of covered entity] is required by law to protect your health information. By signing this document, you authorize [name of 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.

Please note that [include the appropriate statement]:

* You do not have to sign this Authorization, but if you do not, you may not be able to participate in the research or receive research-related treatment if that is a part of the research.

Please note that [include the appropriate statement]:

* You may change your mind and revoke (take back) this Authorization at any time, except to the extent that researchers at Chapman [and name of the covered entity(ies)] has already acted based on this Authorization. To revoke this Authorization, you must write to:
  + [the PI of this study]
  + [name of the covered entity(ies)]
* Even if you revoke this Authorization, [name or class of persons at the covered entity involved in the research] 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.

This Authorization does not have an expiration date [or as appropriate, insert expiration date or event, such as “end of the research study.”]

**[OPTIONAL ELEMENTS]**

Examples of optional statements/elements that may be relevant to the research and could be included on the Authorization Form.

* Your health information will be used or disclosed when required by law.
* Your health information may be shared with a public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, and conducting public health surveillance, investigations, or interventions.

* No publication or public presentation about the research described above will reveal your identity without another authorization from you.
* If all information that does or can identify you is removed from your health information, the remaining information will no longer be subject to this authorization and may be used or disclosed for other purposes.
* If you revoke this Authorization, you may no longer be allowed to participate in the research described in this Authorization.

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Signature of participant Date

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Printed name of participant

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Signature of participant’s personal representative Date

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Printed name of participant’s personal representative

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A description of the personal ­­­­representative’s

authority to sign for the participant.