

MAIN LINE HOSPITALS
Authorization Form for Use and Disclosure of
Protected Health Information for Research

.16I authorize the use and/or disclosure of my individually identifiable private health information as described below. I understand that this authorization is voluntary and that if the organization authorized to receive this information is not a health plan or healthcare provider, the release of such information may no longer be protected by federal privacy regulations. I also understand that once this information is used and/or disclosed as stated in this authorization it may be subject to re-disclosure by the recipient(s) and may no longer be protected by federal privacy regulations.

Subject's Name _____

Title of Research: _____

Principal Investigator: _____

MLH IRB File Number: _____

Person(s) or class of persons authorized to use and/or disclose the information:

Person(s) or class of persons authorized to receive the information:

Description of the information that may be used and/or disclosed: *(please state clearly)*

The information will be used and/or disclosed for the following purpose(s):

Description of any information to be submitted to the health insurance plan of the research subject for reimbursement of costs of care associated with the study protocol.

MAIN LINE HOSPITALS
Authorization Form for Use and Disclosure of
Protected Health Information for Research

There is no expiration date for the use and/or disclosure of your protected health information.

I understand that I may revoke this authorization at any time in writing by completing the Main Line Hospitals Revocation of Authorization for Use and Disclosure of Protected Health Information Created for Research (MLHHPA Form 007). I understand that the disclosures made in good faith may have already occurred in reliance with this authorization and that a revocation cannot apply retroactively to such disclosures. I understand that if I revoke this authorization, I will no longer be eligible to participate in the study. I also understand that in the event I do revoke this authorization, it will not have any effect on my present or future medical care at Main Line Hospitals.

Uses and/or disclosures of protected health information may be made if (1) required by law, (2) the use and/or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, and (3) the disclosure is made to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat to the health or safety of a person or the public.

I have the right to see and copy my personal health information related to this study. However, to ensure the scientific integrity of the research, I agree to wait until the conclusion of the study before exercising this right.

I authorize the use and/or disclosure of my individually identifiable private health information as described above. I will receive a copy of this signed authorization form.

The following information in BLUE should only be added if the research study will involve optional research activities:

Optional Research:

The research I am agreeing to participate in has additional optional research activities such as a tissue repository, quality of life study, blood or tissue collections for laboratory studies and/or biobanking for possible future studies or other activities, as explained to me in the research study informed consent form, I understand I can choose to participate and agree to the following:

- | | |
|---|---------------------------|
| <input type="checkbox"/> I agree to allow my information to be disclosed for the additional optional research activities explained and agreed to in the research study informed consent form. | Subject Initials
_____ |
| <input type="checkbox"/> I do not agree to allow my information to be disclosed for the additional optional research activities explained in the research study informed consent form. | _____ |

The signature lines below should be included for all studies EXCEPT for research which will involve subjects that are not able to give informed authorization (see page 3):

Printed Name of Research Subject

Printed Name of Principal Investigator
or person obtaining authorization

Signature of Research Subject

Signature of Principal Investigator or person obtaining
authorization

Date

Date

