

## SAMPLE HIPAA RESEARCH AUTHORIZATION

*Insert information where requested and italicized (i.e. name of research institution, etc. Please remove this portion of the document before submitting.)*

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### **Authorization for the Disclosure and Use of Your Health Information**

By signing this authorization form, you are authorizing William Beaumont Army Medical Center, including the Principal Investigator (*name of investigator*), and other members of the research staff, to use and disclose your health information for the following purposes: (*describe purposes of usage or disclosures*). This health information includes demographic information (i.e. age, sex, race, etc.), medical/surgical history, imaging studies, laboratory results, and any other health information relating to this research study.

Your health information may be disclosed to Institutional Review Boards that review this research and state and federal government agencies, including, but not limited to, the Food and Drug Administration (FDA), the Department of Health and Human Services, and Department of Defense regulatory agencies to make sure that it has been handled in an ethical and confidential manner. Health information that has been disclosed may be re-disclosed by the recipient of the information; information that has been re-disclosed is no longer protected under this HIPAA authorization.

(*Include one of the following: (1) "There is no expiration date for this authorization" or (2) "This authorization expires when [insert an expiration date or expiration event that relates to the individual or the purpose of the use or disclosure. For example, "the FDA grants final approval of the tested product, or upon final publication of the results of the research, whichever comes later." ]*). All protected health information gathered throughout the life of the study will be destroyed in accordance with applicable regulations at this time.

You have the right to revoke this authorization in writing, unless William Beaumont Army Medical Center has already taken action relying on this authorization. You may revoke this authorization by writing to the Principal Investigator at 5005 N. Piedras Street, El Paso, TX 79920. If you revoke this Authorization, you will no longer be included in this research study; however, information gathered up until that time will be included.

Any medical treatment that is to be provided as part of this research study will be provided only if you authorize the uses and disclosures of your health information as described.

*Insert only if the study is blinded:* "William Beaumont Army Medical Center will not disclose your health information to you during the course of the research study. You may

request copies of records containing your health information after the research is completed.”

If you have not already received a copy of the Military Health System Notice of Privacy Practices, you may request one. If you have any questions or concerns about your privacy rights, you should contact Mr. Jack Bell, Patient Administration Division, at (915) 569-2198.

If you decide not to sign this Authorization, you will not be able to participate in this research study. Refusal to participate in this project and sign this Authorization will not result in any recrimination or loss of medical benefits to which you are otherwise entitled.

You will receive a copy of this form after it is signed.

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Volunteer's signature or Personal Representative

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Date

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Volunteer's Printed Name or Personal Representative