

Study Title (optional):
IRB No.
Principal Investigator:

**USC HIPAA AUTHORIZATION FOR
USE AND DISCLOSURE OF HEALTH INFORMATION
IN CONNECTION WITH RESEARCH STUDY**

The Health Insurance Portability and Accountability Act (HIPAA) and California Law:

A federal law known as the Health Insurance Portability and Accountability Act (HIPAA) protects how your health information is used for certain purposes.

HIPAA requires that you give your written permission to release your “Protected Health Information” to members of the research team to use for this research study. “Protected Health Information” is any identifiable health information about your past, present or future physical or mental health condition or payment for health care. Examples of protected health information include: medical or dental records, billing records, identifiable tissue samples and x-rays. State law also gives you certain protections regarding the use and release of your health information.

This form authorizes your health care providers to release your health information to members of the research team and others for research purposes. It also describes how your health information will be used. You must sign this form to participate in the study.

Authorization to Obtain and Use Health Information From Provider for Research Study:

By signing this document, you authorize (give permission to) the following health care provider(s) checked or described below:

- All health care providers with health information about me
- USC Norris Cancer Hospital
- USC University Hospital
- Childrens Hospital Los Angeles
- LAC+USC Medical Center
- USC Care Medical Group, Inc. and its affiliated practice plans
- The researcher/clinician generating health information through this study
- Other: _____ (please specify)
- Other: _____ (please specify)
- Other: _____ (please specify)
- Other: _____ (please specify)

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To release the following information: *[check the box that applies]*

- All of your medical or other patient records and other protected health information that the provider has in his or her possession, including information relating to any patient history, mental or physical condition and any treatment you received. (This section does not include HIV test results, certain inpatient mental health records, and drug and alcohol treatment records protected under federal law, which require your separate authorization below).

- Only the following records or types of health information: (Insert dates of treatment, types of treatment or other designation.)

- Any and all health information that is generated in the course of the research study

- _____ HIV test results. *[This box must be separately initialed by the subject if applicable]*

- _____ Mental health treatment records governed under state law (including mental health records relating to involuntary or voluntary mental health treatment).
[This box must be separately initialed by the subject on the line above if applicable]

- _____ Substance abuse (drug and alcohol) treatment records.
[This box must be separately initialed by the subject on the line above if applicable]

To the following individuals or entities for the following purposes:

- Researchers (those individuals in charge of the study), research staff, including nurses, technicians and administrators, students involved with the research project, such as graduate assistants, medical or professional trainees and other members of the research team for purposes of the research study as described in the attached informed consent

- The research sponsor, its affiliates, subcontractors and representatives for purposes of conducting, evaluating, overseeing or otherwise assisting with this research study and the related research activities of the sponsor

- The relevant USC Institutional Review Board (IRB), Health Research Association (HRA), the USC HIPAA Privacy office, funding agencies and relevant government national and international oversight agencies such as the Food and Drug Administration and the Office for Human Research Protections and as otherwise required by law

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Authorization to Use Health Information for a Research Database:

[Please remove this provision if not applicable to your study]

Health care researchers will often review existing health information from large groups of patients in order to test or validate theories that the researcher develops. This is sometimes called records research or database research. USC maintains such databases, often grouping together patient information for purposes of future medical or other health research. This authorization also permits USC to include the health information about you that USC has in its possession in USC research databases for the purpose of future medical or other health research.

This authorization only allows USC to use your health information for purposes of entering the data and maintaining the USC research databases. USC will not allow researchers further access to the USC database for research purposes unless USC obtains a specific authorization from you or unless such use or disclosure is specifically required or permitted by law.

This section of the Authorization will remain in effect indefinitely from the date of this Authorization.

Use and Disclosure of Health Information by Pharmaceutical Company Sponsor:

[applicable to pharmaceutical companies only. The subject does not have to agree to this provision in order to participate in the study. If the subject does agree, he/she must initial where indicated in order for the authorization to be valid. Please remove this provision if not applicable to your study]

_____ The sponsor of this research study is authorized under this section to receive your health information and to use such information in connection with the research study. However, if the research sponsor is a pharmaceutical company, state law requires the sponsor to obtain your written permission to use or release your health information for any other purpose. By initialing this section, you expressly permit the sponsor, if it is a pharmaceutical company, to use your health information for the purposes set forth below. The sponsor will not use your health information for marketing or any purpose not expressly stated in this Section. Specifically, the sponsor only will use and release your health information for the following purposes not directly related to your enrollment in the research study:

You are not required to agree to this section in order to participate in the study.

Limits of this Authorization:

Under USC policies, USC personnel identified above who have access to your health information as part of this study, may not use the information for purposes other than this study, except as otherwise permitted by law. In addition, while health information that is shared with others outside USC may not be protected by HIPAA once disclosed, it may nonetheless remain protected under relevant California or other state privacy laws.

Right to Deny Access to Health Information:

During the course of this study, you may be denied access (to inspect or copy) to some or all information generated for this research study. Subject to applicable law, you are entitled to access this health information once the research study is completed.

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Term of this Authorization:

Except for database research, if applicable, this authorization for USC to use your health information described above for purposes of the research study expires _____ years from the date of your signature or at the end of the research study (including all data collection and analysis), whichever is sooner, unless you revoke this authorization as described in the next section.

Refusal to sign/Right to Revoke:

You must sign this Authorization in order to participate in this research. You may change your mind and revoke (e.g., withdraw or cancel) this authorization and your participation in this research study at any time. To do so, your revocation must be in writing to the appropriate Institutional Review Board (IRB) and include: (1) the title of the research study; (2) the name of the Principal Investigator; and (3) your name and telephone number or address. Please send the revocation to the following IRB address:

From and after the date your notice of revocation is received, you will not be allowed to participate any further in the research and we will stop collecting your health information. However, even if you revoke this authorization and your participation in this research study, we may still use and share your health information already obtained as necessary to maintain the integrity of the research study.

Questions regarding your privacy rights:

The address of USC’s Privacy Office is 3500 Figueroa, Suite 105, Los Angeles, CA 90089-8007, and you may contact the Privacy Office by telephone at 213-740-8258.

Agreement:

I have read (or someone has read to me) the information provided above. I have been given the opportunity to ask questions and all of my questions have been answered to my satisfaction. My signature below indicates that I authorize the use and disclose my health information as described in this document.

Name of Subject	Signature	Date of Birth	Date Signed
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If Individual is unable to sign this Authorization, please complete the information below:

Name of Legal Guardian/ Personal Representative	Signature	Legal Relationship	Date
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You will be provided with a signed copy of this authorization.