

Protocol Title: \_\_\_\_\_  
\_\_\_\_\_

Principal Investigator Name: \_\_\_\_\_

Version Date: \_\_\_\_\_

IRB #: \_\_\_\_\_

**Parent or Guardian  
Research Authorization Form  
University of Wisconsin-Madison**

Researchers at the University of Wisconsin-Madison (UW) are required to get written permission from a child's parent or guardian to use the child's identifiable health information in a research study. This permission is called an "Authorization." In order for your child to take part in this research study you must sign this Authorization form.

**A. How will my child's identifiable health information be used?**

Your child's health information will be used to:

**B. What information will be used?**

The following information about your child's health will be used for this research study:

**C. Who will use my child's identifiable health information?**

The people who hold your child's medical records will share your child's identifiable health information with the UW researchers, who may also share it with other people outside UW. (If your child's identifiable health information will be shared outside UW-Madison, those outside institutions and researchers receiving your child's health information will be listed below.)

1. Record Holders:
  - *[Describe]*
2. Researchers and Others within the UW:
  - *[Research team, etc.]*
  - UW-Madison regulatory and research oversight boards and offices
  - Research support services staff at the UW-Madison and its affiliates
3. Researchers and Others outside the UW:
  - *[Describe, if any]*

A copy of the research consent/HIPAA authorization form may be placed in your child's medical record. Additionally, information about medications, tests and other procedures conducted as part of the research study may also be placed in your child's medical record if relevant to your child's clinical care, and may be viewed by individuals with access to your child's medical record (e.g. other health care providers).

An electronic research record, much like your child's electronic medical record, will also be

created any time your child participates in a clinical research study at the UW. Information as described above pertaining to the research study will also be placed in your child's electronic research record, including demographic information which may come from your child's medical record.

**D. How long will the permission last?**

This Authorization does not have an end date. You can end this Authorization at any time, however, by withdrawing your permission in writing. Beginning on the date your permission ends, no new identifiable health information will be used. Any identifiable health information that was shared before you withdrew your permission will continue to be used. After this Authorization ends, your child can no longer actively take part in this research study.

Withdrawal of your permission should be made in writing to the person whose name is listed here:

*[Principal Investigator's name and address]*

**E. Is my permission voluntary?**

Your permission is voluntary. You do not have to sign this Authorization form and you may refuse to do so. Your child's health care providers must continue to provide your child with health care services even if you refuse to sign this Authorization form. If you refuse to sign this form, however, your child cannot take part in this research study.

**F. How will my child's identifiable health information be protected?**

Whenever possible your child's health information will be kept confidential. Federal privacy laws (e.g. HIPAA) may not apply to some people outside of UW who are not health care providers and who can share your child's health information without your permission. If you signed a consent form for your child to take part in this research, more information about confidentiality protections may be found there.

**G. Additional information.**

You should take as much time as you need to make your decision about giving permission for the use of your child's identifiable health information for this research study. Please ask any questions you have about this Authorization form.

**Certification: I have read this Authorization form describing how my child's identifiable health information will be used. I have had a chance to ask questions about the use of my child's identifiable health information and I have received answers to my questions. I agree to the use of my child's identifiable health information for this research study.**

**Child's name:**

(Please print) \_\_\_\_\_

**Parent or Guardian Name**

**Signing Authorization:**

(Please print) \_\_\_\_\_

**Signature of Parent or Guardian:**

\_\_\_\_\_ **Date:** \_\_\_\_\_

**Relationship to Child:** \_\_\_\_\_

(Please print)

**\*\*YOU SHOULD RECEIVE A COPY OF THIS FORM AFTER SIGNING IT\*\***

**Signature of person obtaining Authorization:**

\_\_\_\_\_ **Date:** \_\_\_\_\_