Protocol Title: _____
_____

Principal Investigator Name: _____

Version Date: _____

IRB #: _____

Research Authorization Form
University of Wisconsin-Madison

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

A. How will my identifiable health information be used?

Your health information will be used to:

B. What information will be used?

The following information about you and your health will be used for this research study:

C. Who will use my identifiable health information?

The people who hold your medical records will share your identifiable health information with the UW researchers, who may also share it with other people outside UW. (If your identifiable health information will be shared outside UW-Madison, those outside institutions and researchers receiving your 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 medical record. Additionally, information about medications, tests and other procedures conducted as part of the research study may also be placed in your medical record if relevant to your clinical care, and may be viewed by individuals with access to your medical record (e.g. other health care providers).

An electronic research record, much like your electronic medical record, will also be created any time you participate in a clinical research study at the UW. Information as described above

pertaining to the research study will also be placed in your electronic research record, including demographic information which may come from your medical record.

D. How long will my 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, you 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 health care providers must continue to provide you with health care services even if you refuse to sign this Authorization form. If you refuse to sign this form, however, you cannot take part in this research study.

F. How will my identifiable health information be protected?

Whenever possible your health information will be kept confidential. Federal privacy laws (e.g., HIPAA) may not apply, however, to some people outside of UW who are not health care providers or health care insurers who can share your health information without your permission. If you signed a consent form 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 identifiable health information for this research study. Please ask any questions you have about this Authorization form.

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

Signature of individual or personal representative:

_____ **Date: _____**

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

If this Authorization form is signed by a personal representative, please print his or her name and relationship to the individual:
Name (print): _____
Relationship: _____

Signature of person obtaining Authorization:

_____ Date: _____