

JMA IRB X 10
05-02-10-06 FR

**AUTHORIZATION TO CONTACT YOU ABOUT
FUTURE RESEARCH STUDIES**

You are being asked to read and sign this form because you are a patient in Women's Mood Disorders Center. The Center has several research studies, which aim to learn more about the diagnosis, evaluation and treatment of mood disorders in women. The Center also works with other researchers at Hopkins on other studies also intended to learn more about this area.

We would like your permission for the research team members in the clinic and other researchers working with the team to review your medical records in clinic to determine whether you might be eligible to join any of these research studies. This is called "screening". If you agree, then we might contact you in the future and tell you about a research study. At that time, you could decide whether or not you are interested in participating in a particular study.

Your permission to do this screening would be greatly appreciated, but it is completely voluntary. If you choose not to allow this screening, it will not affect your care at any of the Johns Hopkins Medical Institutions. Please understand that giving your permission to do this screening is only for the purpose of helping us identify patients who may qualify for a particular study. It does not mean that you must join in any study. That is a separate decision that you would make at a later time.

The only people who would look at your medical records would be researchers and their staff from the clinic and other researchers at Hopkins working with the team. All of them know how important it is to keep the health information you share with us protected. We do not expect to share this information with anyone outside of Hopkins. If it is shared with anyone outside of Hopkins inadvertently, we will do everything we can to protect your information, but, in such an event, we cannot guarantee protection.

If you give us permission to do this screening, your authorization will remain in effect for five (5) years or until you tell us in writing that you have decided to cancel your permission. You can do so at any time by sending a written notice to the Privacy Officer, The Johns Hopkins Health System, 600 N. Wolfe Street, Administration 400, Baltimore, Maryland 21287; or sending a notice by e-mail to hipaa@jhmi.edu, or by notifying your physician.

May we use your health information to see if you are eligible for a future study and contact you to tell you about that study?

CIRCLE ONE: YES NO

This form applies only to contact about research conducted by the Women's Mood Disorder Clinic at Johns Hopkins. Please note that it is possible that you may be contacted by a researcher from another department about research conducted by another department.

Print Name of Individual Able to Give Permission: _____

Signature of Adults or Children Able to Give Permission _____ Date _____

Signature of Surrogate/Guardian/Health Care Agent on Behalf of an Adult Not Able to Give Permission _____ Date _____

Signature of Parent or Legal Guardian on Behalf of a Child Not Able to Give Permission _____ Date _____

APPROVED
FEB 23 2005
Effec. Date 3/04
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