**HIPAA AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR RESEARCH**

**Protocol Title**:

Application No.:

**Principal Investigator**: ***<<Include name, address, email address, and phone information*>>**

This privacy form tells you what information about you may be collected in the study and who might see or use it.

**What information is being collected, used, or shared?**

To do this research, we will need to collect, use, and share your private health information. By signing this document, you agree that your health care providers (including both Johns Hopkins Medicine and others) may release your private health information to us, and that we may use any and all of your information that the study team believes it needs to conduct the study. Your private information may include things learned from the procedures described in this consent form, as well as information from your medical record (which may include information such as HIV status, drug, alcohol or STD treatment, genetic test results, or mental health treatment).

**Who will see, use or share the information?**

The people who may request, receive, or use your private health information include the researchers and their staff who may be a part of Johns Hopkins Health System, Johns Hopkins University or the Johns Hopkins Applied Physics Laboratory. Additionally, we may share your information with other people at Johns Hopkins, for example if needed for your clinical care or study oversight. To improve coordination of your research and clinical care, some information about the study you join will be included in your electronic medical record.

By signing this form, you give permission to the research team to share your information with others outside of Johns Hopkins. This may include the sponsor of the study and its agents or contractors, outside providers, study safety monitors, government agencies, other sites in the study, data managers and other agents and contractors used by the study team.

We try to make sure that everyone who sees your information keeps it confidential, but we cannot guarantee that your information will not be shared with others. If your information is disclosed by your health care providers or the research team to others, federal and state confidentiality laws may no longer protect it.

**Do you have to sign this Authorization?**

You do not have to sign this Authorization, but if you do not, you may not join the study.

**How long will your information be used or shared?**

Your Authorization for the collection, use, and sharing of your information does not expire. Additionally, you agree that your information may be used for similar or related future research studies.

**What if you change your mind?**

You may change your mind and cancel this Authorization at any time.  If you cancel, you must contact the Principal Investigator in writing to let them know by using the contact information provided in this consent form.  Your cancellation will not affect information already collected in the study, or information that has already been shared with others before you cancelled your authorization.

**WE WILL GIVE YOU A COPY OF THIS SIGNED AND DATED FORM**

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Signature of Participant (Print Name) Date/Time

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Signature of Person Obtaining Consent (Print Name) Date/Time

<<Add any of the following that are applicable and delete any that do not apply>>

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Signature of Legally Authorized Representative (LAR) (Print Name) Date/Time

**For ADULTS UNABLE TO CONSENT**

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Relationship of LAR to Participant

(Indicate why the LAR is authorized to act as a surrogate health care decision-maker under state or applicable local law)

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Signature of Parent/Legal Guardian/Court-Appointed Representative (Print Name) Date/Time

**FOR CHILD PARTICIPANT**

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Description of relationship to child research participant (for example: parent, legal guardian, court-appointed representative)

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Signature of Parent #2 (Print Name) Date/Time

(Required if DHHS 45 CFR 46.406 or 46.407/FDA 21 CFR 50.53 or 50.54 study)

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Signature of Child Participant (optional unless IRB required) (Print Name) Date/Time

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Signature of Interpreter/Impartial Witness to Consent Procedures (Print Name) Date/Time

(Required for studies enrolling non-English speakers using the short form process or otherwise as determined required by the IRB)