FINANCE 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

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