

Subject Name:

Date:

Title of Study:

(enter title here on page 1)

Principal Investigator:

(enter name of PI here on page 1)

VAMC: John D. Dingell
VA Medical Center

REQUEST FOR PATIENT AUTHORIZATION FOR ACCESS TO PROTECTED HEALTH INFORMATION

1. By signing this document, you authorize the Veterans Health Administration (VHA) to provide **(insert name of Principal Investigator)** and his or her research team to access your Protected Health Information (medical chart data) for research purposes. This information may include the following:
Hospital records and reports; admission history, and physical; X-ray films and reports; operative reports; laboratory reports; treatment and test results; psychotherapy notes; dental notes; immunizations; allergy reports; prescriptions; consultations; clinic notes; and any other medical records needed by the research team.
(This list may be edited by the research PI, please delete this line)
2. Your Protected Health Information will be used for the following research purposes:
(Brief description to be completed by research PI, please delete this line)
3. You may refuse to sign this authorization and refuse to allow the disclosure of your Protected Health Information. Your refusal will not affect your ability to receive medical care or benefits at the Detroit VAMC.
4. ***(PI must select one of the following choices and delete the rest)***
This authorization will expire at the end of the research study
This authorization will expire at this date _____
This authorization will expire at this event _____
This authorization has no expiration date
5. This authorization may be revoked at any time by sending a written request to **(PI name and address here)**
If you revoke this authorization, **(insert name of Principal Investigator)** and his or her research team can continue to use information about you that has been collected. No information will be collected after you revoke the authorization.
6. The Detroit VAMC complies with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its privacy regulations and all other applicable laws that protect your privacy. We will protect your information according to these laws. Despite these protections, there is a possibility that your information could be used or disclosed in a way that it will no longer be protected.
7. ***Insert the following if the study has a sponsor outside the VHA (i.e., pharmaceutical company):***
As part of the study, we may disclose your information to **(insert name of sponsor)**, the sponsoring company for this research study. We will not share any information with the sponsor unless the sponsor agrees to keep the information confidential and use it only for the purposes related to the study. Any information shared with the sponsor may no longer be protected under federal law.
8. ***(Insert the following if the study includes the creation of a database or tissue repository):***
This study includes the creation of a database of information or specimens such as blood, tissue, or other bodily fluids that will be used in future research. By signing this authorization, you agree to allow the information collected in this study to be added to that database.

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I have read this authorization form and have been given the opportunity to ask questions. If I have questions later, I understand I can contact Dr. _____. I will be given a signed copy of this authorization form for my records. I authorize the use of my identifiable information as described in this form.

X _____ X _____ X _____
Signature of Individual/Legal Representative Print Name Date

If signed by a legal representative, state the relationship below and identify the relationship and the authority to act on behalf of the individual.

Relationship:

***Individual is a:**

___ Minor ___ Incompetent ___ Disabled ___ Deceased

***Legal Authority:**

___ Custodial Parent ___ Legal Guardian ___ Executor of Estate of the Deceased

___ Power of Attorney/Healthcare ___ Authorized Legal Representative

___ Other _____