Authorization for Use & Release of Individually Identifiable Health Information for Veterans Health Administration (VHA) Research

Subject Name (Last, First, Middle Initial)**:**	**Subject SSN** (last 4 only)**:**	**Date of Birth:**

VA Facility (Name and Address)**:**

VA Principal Investigator (PI)**:**	**PI Contact Information:**

Study Title:

Optional Authorization Supplement for Placing My Data or My Biological Specimens in a Repository or for Conducting Optional Analysis of My Specimens for Future Use in Research

Purpose. This supplement to the authorization is for either banking of data and/or biological specimens (for example blood, urine, tissue) collected during the study for future research or for conducting optional analysis for this study . You are not required to provide this permission and not providing this permission will have no impact on your participation in this study, i.e., granting this permission is not a condition of participating in this study.

Research Subject Signature. This additional permission (authorization) has been explained to me and I have been given the opportunity to ask questions about this activity. By signing below, I am giving my permission for VHA to:

☐ Store my health information in a research data repository at _____

and sponsored/run by _____

☐ Store my biological specimens (blood, tissue, urine, etc.) in a research biological specimen/tissue repository at _____

and sponsored/run by _____

☐ Further optional analysis of my specimens for the current study occurring below:

Future research of data maintained within a research data repository will only occur after further Institutional Review Board and/or other applicable approvals of the new research to ensure the protection of your individual privacy. Future use of my biological specimens will only occur after the new research has been approved by all required committees.

Signature of Research Subject _____ Date _____

Signature of Legal Representative (if applicable) _____ Date _____

To Sign for Research Subject (Attach authority to sign: Health Care Power of Attorney, Legal Guardian appointment, or Next of Kin if authorized by State law)

Name of Legal Representative (please print) _____