LSU Health NEW ORLEANS

INSTITUTIONAL REVIEW BOARD

Health Insurance Portability and Accountability Act (HIPAA) Authorization for Use and Disclosure of Protected Health Information (PHI) for Research Purposes

Instructions for Investigators
This form must be reviewed and signed by patients participating in research/clinical trials that require a signed Informed Consent. These documents should be kept together. A copy of this Authorization and the Informed Consent must be given to the patient and/or his/her representative.)

Title of Research Project

Sponsor Name & Protocol #, if applicable _____

Principal Investigator _____ IRB # _____

I hereby request and authorize the LSUHSC-NO to use and disclose protected health information from the record(s) of:

Patient's Name _____

Patient's Address _____

Patient's Birth Date _____

Specifically, I request and authorize any part of my health information relevant to the research project, identified above and in the Informed Consent document, to be used and/or disclosed to the Principal Investigator identified above or his/her designee, in connection with the research project. I understand that this may include information relating to: Human Immunodeficiency Virus ("HIV") infection or Acquired Immunodeficiency Syndrome ("AIDS"); treatment for or history of drug or alcohol abuse; and/or mental or behavioral health or psychiatric care.

I specifically authorize the use and disclosure of the following Protected Health Information. **Check A or B**. If B is checked, indicate which document(s) (1 – 14) on page two are being requested.

☐ A. Complete health record(s) from ─ to (enter specific dates or specific events below).

Complete health record(s) may contain all of the documents listed under B (1-14), as well as other notes or documents relating to my treatment or hospitalization.

OR

☐ B. One or more of the specific documents listed on page two. Documents should provide a detailed description of the particular data requested and period of time for which records are requested (from ─ to: defined as specific dates or specific events).

☐ 1. History and Physical Exam _____

☐ 2. Hospital Inpatient Records _____

☐ 3. Clinic/Outpatient Records _____

☐ 4. Consultation Reports _____

☐ 5. Laboratory Test Results _____

☐ 6. Radiology Reports _____

☐ 7. Pathology Reports _____

☐ 8. Discharge Summary _____

☐ 9. Progress Notes _____

☐ 10. Photographs, Videotapes _____

☐ 11. X-Ray Films/Images, Digital or Other Images _____

☐ 12. Diagnosis and Treatment Codes _____

☐ 13. Complete Billing Record _____

☐ 14. Other (specify) _____

_____

_____

_____

I understand that copies of the records indicated above will be:

- Used by employees of LSUHSC-NO including treatment providers, and/or other members of its workforce.
- Disclosed to government officials or government agencies, study sponsors, study monitors, or others responsible for oversight of the research project.
- Sent to collaborating researchers outside LSUHSC-NO if and to the extent indicated in the attached Informed Consent document(s).

I understand that by signing this form, I will allow LSUHSC-NO and its researchers to use or disclose my health information in connection with the attached Informed Consent and for the purpose of the research that is described in the Informed Consent. For example, the researchers may need the information to verify that I am eligible to participate in the study, or to monitor the results, including expected or unexpected side effects or outcomes. Other University and government officials, safety monitors, and study sponsors may need the information to ensure that the study is conducted properly. Also, I understand that my health information may be disclosed to insurance companies or others responsible for my medical bills in order to secure payment.

I understand that any privacy rights not specifically mentioned in this Authorization are contained in the Notice of Privacy Practices that I received, or will receive, from the Principal Investigator or at the facility that I attend.

I understand that I may revoke this authorization at any time, except to the extent that LSUHSC-NO has already relied on the authorization, by sending or transmitting of a facsimile, a written notice to the contact person listed in the attached Informed Consent document(s).

I understand that if my information already has been included in a research database or registry as described in the attached Informed Consent document(s), LSUHSC-NO considers itself to have relied on it and, therefore, my information will not be removed from those repositories.

Unless otherwise revoked, I understand that this authorization:

☐ Will not expire or

☐ Will expire upon _____
Enter date or event

I understand that if I do not sign this form, I will not be able to participate in the above research study or receive the study-related interventions, or if I revoke an authorization I previously signed, I will no longer be able to participate in the above research study or receive the study-related interventions, but that LSUHSC-NO cannot otherwise condition treatment on my signing this form.

While the research study is in progress, my right to access any research records or results that are maintained by the facility may be suspended until the research study is over. If my access is denied, I understand that it will be reinstated at the end of the research study.

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act. The LSUHSC facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I understand that this authorization supersedes any contrary information in any other documents I have signed related to the attached study.

_____ _____
Signature of Patient or Patient's Legal Representative Date

_____
Printed Name of Legal Representative (if any)

Representative's Authority to Act for Patient (e.g., relationship to patient)

_____

Verification of Representative's Authority

☐ Viewed driver's license

☐ Viewed Power of Attorney

☐ Viewed other (specify) _____

Clear Form