**[If your study involves the use of Protected Health Information, include the following HIPAA Authorization Section in your Informed Consent Form.[[1]](#endnote-1)]**

**PERMISSION TO USE/SHARE HEALTH INFORMATION THAT IDENTIFIES YOU**

Information about you and your health is personal and private, so this information generally cannot be used in research without your written permission. The next few paragraphs tell you about how researchers want to use and share your health information in this research study. Your information will only be used as described here, or as allowed or required by law. Ask questions if you do not understand any part of the research or the use of your health information. If you sign this consent form, you agree to let the researchers use your information in the research and share it with others as described below.

**What is the purpose of the research and how will my information be used?**

You are being invited to take part in this research study which is described at the beginning of this form. The purpose of collecting and using your health information for this study is to help researchers answer the questions that are being asked in the research.

**What information about me will be used? [Tailor the list to reflect only what your study will collect. Collect only what is needed to satisfy the study aims and that which is consistent with the information outlined in the protocol to be collected.]**

* All information in your medical record
* Hospital discharge summaries
* Radiology records or images (MRI, CT, PET scans)
* Medical history or treatment
* Medications
* Consultations
* Laboratory/diagnostic tests or imaging
* EKG and/or EEG reports
* Psychological testing, surveys or questionnaires
* Pathology reports, specimen(s) or slide(s)
* Operative reports (about a surgery)
* Dental records
* Emergency Medicine reports
* Patient Billing or Financial Information
* Other (specify)

**Who may use, share or receive my information?**

The research team may use or share your information collected or created for this study with the following people and institutions:

* Nebraska Wesleyan University researchers involved in the study
* Non-Nebraska Wesleyan University researchers on the study team: [Insert the affiliation and location of researchers at other institutions or organizations. If none, delete this bullet.]
* The Nebraska Wesleyan University Institutional Review Board
* The Office for Human Research Protections in the U.S. Dept. of Health and Human Services
* List every other class of person or organizations not affiliated with Nebraska Wesleyan University to whom the subject’s information might be disclosed (for example, a sponsor of the research, a data safety monitoring board; researchers at other institutions, outside data analysis companies, transcription services, National Institutes of Health, etc.)

Those persons or organizations that receive your information may not be required by Federal privacy laws to protect it and may share your information with others without your permission, if permitted by the laws governing them.

**Will I be able to review my research record while the research is ongoing?**

No. We are not able to share information in the research records with you until the study is over. To ask for this information, please contact the Principal Investigator, the person in charge of this research study.

**Do I have to give my permission?**

No. You do not have to permit use of your information. But, if you do not give permission, you cannot take part in this research study. (Saying no does not stop you from getting medical care or other benefits you are eligible for outside of this study.)

**If I say yes now, can I change my mind and take away my permission later?**

Yes. You may change your mind and not allow the continued use of your information (and to stop taking part in the study) at any time. If you take away permission, your information will no longer be used or shared in the study, but we will not be able to take back information that has already been used or shared with others. If you say yes now but change your mind later for use of your information in the research, you must write to the researcher and tell him or her of your decision: [insert the investigator’s name and address here].

**How long will my permission last?**

Your permission for the use and sharing of your health information will last until [List a specific date or event on which the subject’s permission for their health records will expire. (For example, “July 1, 2016,” or “end of the research study.”) If a participant’s permission for their health records will not end, consider using the following sentence: “There is no set date when your permission will end. Your health information may be studied for years.”].

1. Recognition and appreciation is given to the Office of Research Regulatory Affairs at Rutgers University for the template from which this form was adapted. <https://orra.rutgers.edu/hspp> [↑](#endnote-ref-1)