HIPAA Research Authorization Form

What is HIPAA?

HIPAA is the Health Insurance Portability and Accountability Act of 1996 that keeps patient health information private and secure. When we say "you" or "your", we are talking about the person who takes part in the research and the person who gives the permission to be in the research.

What is the purpose of this form?

We are asking you to take part in the research described in the consent form. We will need to collect the following information from you:

HIPAA recognized 18 identifiers (remove this list once you have listed those identifiers needed for your research)

1. Names;
2. All geographic subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes;
3. All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death;
4. Telephone numbers;
5. Fax numbers;
6. Electronic mail addresses;
7. Social security numbers;
8. Medical record numbers;
9. Health plan beneficiary numbers;
10. Account numbers;
11. Certificate/license numbers;
12. Vehicle identifiers and serial numbers, including license plate numbers;
13. Device identifiers and serial numbers;
14. Web Universal Resource Locators (URLs);
15. Internet Protocol (IP) address numbers;
16. Biometric identifiers, including finger and voice prints;
17. Full face photographic images and any comparable images;
18. Any other unique identifying number, characteristic, or code.

- *List information to be collected for the purpose of this research*

[Explain what the above information will be used for and how this information will help benefit this research study.]

To be in this study, we need your permission to collect, create, and share information. We will only ask for information needed for the research. Being part of this study will …[explain what the purpose of the collect of your data will do for the research]:

What will happen with my health information?

If you sign this form, your (de-identified) health information may be shared with… *[explain who will have access to this health information and why they will have access to this information for the benefit of the research. These could be people who help with the research or things related to research, such as]:*

(Examples)

- ✓ UCA IRB (University of Central Arkansas Institutional Review Board) and research compliance office
- ✓ the study team
- ✓ other institutional oversight official

What happens if I sign this form?

Signing this form means you give permission for you to be in this research study. You are giving us permission to create, collect, use and share your health information as described in this form. The permission you give us will be in effect until the end of the research study or until you tell us to stop.

What if I don't sign this form?

You do not have to sign this form. If you decide not to sign this form, you cannot be in the research study.

If you decide not to sign this form or change your mind later, this will not affect your current or future medical care, employment or benefits at UCA.

What if I sign this form but change my mind later?

You can change your mind at any time. If you want to leave this study, follow these steps:

- Write a letter saying you have changed your mind and that you are "revoking your HIPAA Research Authorization."
- Write the study title listed on this form in your letter.
- Sign the letter.
- Send the letter to the PI (Principal Investigator) at the following address:

Name of Principal Investigator
Institutional affiliation
Institution address
Institution email address

When does this permission expire?

It expires at the end of the research project.

By signing the document, I am saying:

- I understand that joining this study is voluntary.
- I agree that I can be part of the study.
- Someone talked with me about the information in this document and answered all my questions.

I know that:

- I can stop the study at any time and nothing bad will happen to me.
- I can call the offices that supervise research (UCA IRB) at (501) 852-7460 if I have any questions about the study or about my rights.
- I do not give up any of my rights by signing this form.

I agree that I will participate in this study.

Your Name _____
(please print)

Your Signature _____

Date _____

Printed Name of Researcher _____

Signature of Researcher _____

Date _____

Original form to: Research File

Copies to: Subject/Participant