

**OKLAHOMA STATE UNIVERSITY
CENTER FOR HEALTH SCIENCES**

**AUTHORIZATION FOR THE SHARING OF HEALTH INFORMATION
RELATED TO POSSIBLE PARTICIPATION IN A RESEARCH STUDY**

[This authorization should not be placed on departmental letterhead – it should be on letterhead from the covered entity]

Title of Research Study:

Research Study Investigator(s): *[List the names, addresses, and telephone numbers of the principal investigator and all co-investigators].*

What is the purpose of this authorization?

Your doctor or a member of your doctor's health care staff has discussed with you that you may be eligible to take part in the above-named research study. You have indicated an interest in learning more about this research study from the researchers who are involved in conducting the study. Thus, your authorization (permission) is being requested to:

- share the fact that you are interested in participating in this study with the involved researchers;
- share your health information related to your eligibility to take part in this study with the involved researchers; and
- allow the involved researchers to contact you so as to permit additional discussions of this study with you and/or to provide you with information on how you may take part in this study.

What information about me will be shared with the researchers?

If you give your permission, the following information about you will be shared (for example, by telephone or FAX) with the researchers involved in the conduct of the above-named research study to determine your eligibility for the study:

- your name, address, and telephone number
- your health information related to your *[specify the disease or condition that coincides with the eligibility criteria for participation in the identified research study and a detailed description of the information needed such as complete past medical history, information about HIV or other communicable diseases, lab and other test results, medication records, mental health diagnoses, etc.]*

To whom will the above information be given?

We will share this information with one of the researchers listed above or a member of their research staff. This information will be used by the researchers to evaluate if you are eligible to participate in this research study and/or to contact you to further discuss this research study with you.

These researchers recognize the importance of maintaining the confidentiality (privacy) of your health information, however it is not possible for us to guarantee its confidentiality after we have provided it to them.

For how long is authorization valid?

Patient's Initials _____

Once this information has been shared with the researchers, this authorization form will expire. We will not continue to share your future health information with these researchers, nor will we share your health information with any other researchers unless you sign a separate authorization form that permits us to do so.

Is my permission to provide this information to the researchers voluntary?

Your permission to provide this information to the researchers is completely voluntary. Whether or not you provide your permission will have no affect on your current or future medical care or your relationship with your doctor or health care provider. Whether or not you provide your permission will have no affect on your current or future relationship with the Oklahoma State University Center for Health Sciences (“OSU-CHS”).

May I withdraw, at a future date, my permission to provide this information to the researchers?

You may withdraw, at any time, your permission to provide this information to the researchers. However, once this information has been shared with the researchers, the information will be in their possession. Hence, should you decide to withdraw your permission after your information has been given to the researchers, you should send a written and dated notice of this decision to the principal investigator of this research study at the address listed above or call the principal investigator who will prepare a document for you to sign to indicate your withdrawal. Upon receipt of this request, the researchers will destroy your information that was provided to them. If you wish to withdraw your permission to provide this information to the researchers before it is given to them, you should contact, by telephone, your doctor or a member of your doctor’s health care staff. With receipt of this request, your information will not be shared with the researchers.

Your decision to withdraw your permission to provide this information to the researchers will have no affect on your current or future medical care or your relationship with your doctor or health care provider. Your decision to withdraw your permission will have no affect on your current or future relationship with the OSU-CHS.

I UNDERSTAND THAT MY MEDICAL RECORDS MAY CONTAIN INFORMATION THAT INDICATES THAT I HAVE A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT IS NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILLIS, GONORRHEA, OR THE HUMAN IMMUNO-DEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).

VOLUNTARY AUTHORIZATION

All of the above has been explained to me. By signing below I give my permission to share the information, specified above, with the researchers, identified above, for the purposes described.

Printed Name of Patient or Personal Representative,
if patient is a minor or not competent

Basis for Signature by anyone other than patient,
and description of legal authority, documentation of
which is attached, of other than parent of a minor.

Signature of Patient or Personal Representative

Date

Patient’s Initials _____