**Name of Study Volunteer**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Medical Record Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of this Research Study:** *<Title>*

**UMB IRB Approval Number:** *<IRB number>*

Researcher’s Name: *<PI name>*

Researcher’s Contact Information:

 *<Department / Institution name>*

***University of Maryland School of Medicine (UMSOM)***

 *<Street Address>, <Room number>*

 *<Phone number>*

This research study will use health information that identifies you/your child. If you/your child agree to participate, this researcher will use just the health information listed below.

The Specific Health Information To Be Used or Shared:

* *Billing and payment information and the medical information required to justify it.*
* *Research tests [INCLUDE ALL ITEMS THAT APPLY]*

Federal laws require this researcher to protect the privacy of this health information. He/she will share it only with the people and groups described here.

**People and Organizations Who Will Use or Share This Information:**

* Dr. *< PI name >* and his/her research team.
* The sponsor of the study, or its agents, such as data repositories or contract research organizations
* Organization that will coordinate health care billing or compliance such as offices within UMSOM; the University of Maryland, Baltimore (UMB); University of Maryland Faculty Physicians, Inc. (FPI) and the faculty practices of the UMB; University of Maryland Medical System (UMMS) and the Veterans Affairs Maryland Health Care System (VAMHCS).
* *Your health insurer to pay for covered treatments [INCLUDE ALL ITEMS THAT APPLY]*

**This Authorization Will Not Expire. But You Can Revoke it at Any Time**.

To revoke this Authorization, send a letter to this researcher stating your decision. He/she will stop collecting health information about you/your child. This researcher might not allow you/your child to continue in this study. He/she can use or share health information already gathered.

**Additional Information:**

* You can refuse to sign this form. If you do not sign it, you cannot participate in this study. This will not affect the care you/your child receive at:
	+ University of Maryland Faculty Physicians, Inc. (FPI)
	+ University of Maryland Medical System (UMMS)
	+ Veteran Affairs Maryland Health Care System (VAMHCS)

 It will not cause any loss of benefits to which you/your child are otherwise entitled.

* Sometimes, government agencies such as the Food and Drug Administration or the Department of Social Services request copies of health information. The law may require this researcher, the UMSOM, FPI, UMMS or VAMHCS to give it to them.
* This researcher will take reasonable steps to protect your/your child’s health information. However, federal protection laws may not apply to people or groups outside the UMSOM, UMB, FPI, UMMS or VAMHCS.
* Except for certain special cases, you/your child have the right to a copy of your/your child’s health information created during this research study. You may have to wait until the study ends. Ask this research how to get a copy of this information from him/her.

My signature indicates that I authorize the use and sharing of my/my child’s protected health information for the purposes described above. I also permit my doctors and other health care providers to share my/my child’s protected health information with this researcher for the purposes described above.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (printed) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Privacy Questions? Call the UMSOM Privacy Official (410-706-0337) with questions about your/your child’s rights and protections under privacy rules.

Other Questions? Call the researcher named on this form with any other questions.