**AUTHORIZATION TO USE AND DISCLOSE**

**PROTECTED HEALTH INFORMATION FOR RESEARCH**

Signing this document means you allow us, the researchers in this study, and others working with us to use information about your health for this research study. You can choose whether you will participate in this research study. However, in order to participate you must sign both the consent form and this authorization.

This is the information we will use: ***[This description must identify the information in a specific and meaningful fashion. Modify this list as appropriate - delete or add items as necessary]***:

* Name
* Address
* Telephone number
* Family medical history
* Allergies
* Current and past medications or therapies
* Information from a physical examination, such as blood pressure reading, heart rate, breathing rate, and temperature
* ***[List any other personal health information that will be obtained from other sources to be used in the research record, including prior medical history, tests or records from other sites]***

The health information listed above may be used by and/or disclosed (released) to the following, as applicable:

* The sponsor of the study including its agents such as data repositories or contract research organizations monitoring the study;
* Other institutions and investigators participating in the study;
* Data Safety Monitoring Boards;
* Accrediting agencies;
* Clinical staff not involved in the study whom may become involved if it is relevant;
* Health insurer or payer in order to secure payment for covered treatment;
* Parents of minor children if less than 16 years old. Parents of children 16 years old or older require authorization from the child; or
* Federal and state agencies and USC committees having authority over the study such as:
* The Institutional Review Board (IRB) overseeing this study;
* Committees with quality improvement responsibilities;
* Office of Human Research Protections;
* Food and Drug Administration;
* National Institutes of Health; or
* Other governmental offices, such as a public health agency or as required by law.

You may change your mind and revoke (take back) this Authorization at any time. Even if you revoke this Authorization, USC may still use or disclose (release) health information already obtained about you as necessary to maintain the integrity or reliability of the research study. If you revoke this Authorization, you may no longer be allowed to participate in this research study. To revoke this Authorization, you must write to:

***[Provide the PI’s name and address here]***

You will not be allowed to see or copy the information described on this Authorization as long as the research study is in progress. When the study is complete, you have a right to see and obtain a copy of the information.

This authorization does not have an expiration date. After you sign this, you will be given a copy with your signature.

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Signature of Research Participant ages 16 & above\* Date

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Signature of Research Participant’s Legally Authorized Representative Date

(if applicable)

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Printed Name of Research Participant

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Printed Name of Research Participant’s Legally Authorized Representative (if applicable)

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Representative’s Relationship to Research Subject

\*If the research participant is 16 to 18 years of age, signatures of both the research participant and the Legally Authorized Representative are required.