# INSTRUCTIONS: Enter your information in the spaces provided. Ensure the version date is inserted on the right side of the header. Although it is often recommended to use declarative sentences suited for an eighth-grade reading level, adjust the language to an appropriate level so the participant population can readily understand the information. **All text in blue italics is for instruction only and is to be deleted before submission to the HQ USAMRDC Institutional Review Board.**

**Authorization for the Use and Disclosure of Your Health Information**

The Health Insurance Portability & Accountability Act of 1996 (also known as HIPAA) establishes privacy standards to protect your health information. This law requires the researchers to obtain your permission (by signing this form) before they obtain, use or disclose (share) your protected health information for research purposes in the study       *[title of protocol]*.

By signing this form, you are authorizing       *[name of research institution]*, including the Principal Investigator,       *[name of Principal Investigator]*, and other members of the research staff, to use and share your health information for the following purposes:       *[describe purposes of uses or disclosures]*, and as otherwise needed for the research study. This health information includes       *[describe information as specifically as possible]*.

Your health information may be shared with authorized representatives of the following groups:

* US Army Medical Research & Development Command Institutional Review Board
* US Army Human Research Protections Office and other DOD offices charged with oversight of human research
* [The covered entity’s regulatory office(s)]
* [Food and Drug Administration]
* [Department of Health & Human Services, Office for Human Research Protections]
* [The Sponsor]
* [name any other person(s)/organizations to whom information may be disclosed].

Health information that has been shared may be re-disclosed by the recipient of the information; these other organizations may then share your health information with others without your permission.

You do not have to sign this Authorization. If you decide not to sign, it will not affect your medical care or your eligibility for benefits, however you will not be able to participate in the research study.

There is no expiration date for this authorization. *[Alternatively, insert an expiration date or expiration event that relates to the individual or the purpose of the use or disclosure. For example, “when the FDA grants final approval of the tested product, or upon final publication of the results of the research, whichever event comes later.”]*

You have the right to revoke this authorization. To take back your permission, you must send your **written** request to  *[Name of Principal Investigator and complete mailing address]* to inform him/her of your decision. If you take back your permission, the researchers may only use and share the protected health information already collectedfor this research study. If you take back your permission, you *[insert the appropriate word(s): will OR will not]* be allowed to continue to participate in the study.

*[Insert if necessary for the research:* *[Research institution]* will not share your health information with you during the course of the research study. You may request copies of records containing your health information after the research is completed.].

You will receive a copy of this form.

**SIGNATURE OF PARTICIPANT**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Participant

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Participant Date