HIPAA Authorization for Research Study Participation

Participant Name

Date of Birth

Research Study Title

Study ID (if applicable)

Authorization to Use and Disclose Protected Health Information

I authorize the use and disclosure of my health information for participation in the research study described above. This authorization allows the following information to be used/disclosed:

- [ ] Medical Records
- [ ] Test Results
- [ ] Demographic Information
- [ ] Other

If other, specify

Persons/Organizations Authorized to Receive Information

Purpose of Use/Disclosure

Expiration

This authorization will expire on (date/event):

Signature

Signature of Participant or Legal Representative

If Legal Representative, Relationship to Participant

Date