Research Study HIPAA Authorization

Study Title:

Principal Investigator:

Authorization to Use and Disclose Protected Health Information

I authorize the use and disclosure of my health information as described in this form for the purpose of participation in the above research study.

Information That May Be Used and Disclosed

Who May Use and Disclose Information

Who May Receive Information

Purpose of Use and Disclosure

Expiration Date or Event

Right to Revoke

I understand that I have the right to revoke this authorization in writing at any time.

Participant Acknowledgment

I have read this HIPAA authorization and have had all my questions answered.

Participant Name

Signature

Date

Witness Name

Signature

Date