Children's Wisconsin

Kids deserve the best.

HIPAA Authorization Form
Release of Information for Research
IRBNet:
PRO:

Patient's Name: _____ **Date of Birth:** _____

Is the Patient a Minor? Yes / No

Principal Investigator:_____**Version Date:**

Name of Research Study:

Researchers are required to get written permission to use health information in a research study, data registry bank, and/or a tissue bank. This permission is called an "Authorization." If you are a parent or legal guardian of a child who may take part in this study, researchers are required to get written permission from a child's parent or guardian to use the child's health information. When the word "you" appears in this HIPAA Authorization, it refers to you or your son or daughter; "we" means the doctors and other staff.

In order for you or your child to take part in this [select appropriate purpose(s): research study, data registry, tissue bank, or other] you must sign this Authorization form.

A. How will your health information be used?

Your health information will be used to: [example; provide information needed for the research study, saved in what is called a specimen bank for future research].

B. What information will be used?

The following information about your health will be used for this [research study, data registry, tissue bank, or other. Examples: past and present treatment as inpatient or outpatient, history and diagnosis of your disease, laboratory, radiology, and so on.

C. Who will use your health information?

With your permission (authorization), the above-named hospital or clinic that holds your medical records will release medical information to the researchers. The researchers may also share it with other people outside of Children's Wisconsin (CW) as listed below.

The following are the researchers, groups, institutions, etc., outside of CW that your medical information will be shared with:
•

D. How long will the permission last?

This authorization will last until [the end of the study, _____years after the study ends, other event.

You can end this Authorization at any time by withdrawing your permission in writing. Beginning on the date your permission ends, no new health information from you will be used. Any health information that was shared before permission was withdrawn will continue to be used. After this Authorization ends, you can no longer actively take part in this [research study, data registry, tissue bank, or other].

Withdrawal of permission should be made in writing to the person whose name and address is listed here:

PI Name **Address:**
Phone: **Fax:**

E. Is the permission voluntary?

Your permission is voluntary. You do not have to sign this Authorization form. Your health care providers must continue to provide you with health care services even if you refuse to sign this Authorization form. If you refuse to sign this form, you cannot take part in this [research study, data registry, tissue bank, or other].

F. How will your health information be protected?

Whenever possible your health information will be kept confidential. Federal privacy laws, however, may not apply to some people outside of CW who can share your health information without your permission. If you signed a consent form to take part in this research, more information about confidentiality protections may be found there.

G. Additional information.

You should take as much time as you need to make your decision about giving permission for the use of your health information for this [research study, data registry, tissue bank, or other]. Please ask any questions you may have about this Authorization form. A copy of this signed HIPAA Authorization will be kept in your medical record.

I have read this Authorization form describing how my or my child's health information will be used. I have had a chance to ask questions about the use of my or my child's health information and I have received answers to my questions. I agree to the use of my or my child's health information for this [research study, data registry, tissue bank, or other].

_____
Print Patient's Name

_____ _____
Signature of Patient or Parent/Guardian Who is Signing Authorization **Date**

_____
Relationship to Child (If Applicable)

****YOU SHOULD RECEIVE A COPY OF THIS FORM AFTER SIGNING IT****