

**AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION FOR RESEARCH**

You have the right to decide who may review or use your Protected Health Information ("PHI"). The type of information that may be used is described below. This is information that is usually in medical records such as your address and phone number, laboratory tests, medical history, and X-ray reports. When you consider taking part in a research study, you must give permission for your protected health information to be released from your doctors, clinics, and hospitals to the research team, for the specific purpose of this research study. This authorization relates to the following study:

**P. Michael Conneally, Ph.D.** **IRB # 0203-03**  


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*PRINCIPAL INVESTIGATOR (in charge of Research Team)* *IRB PROTOCOL #*

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*NAME OF RESEARCH PARTICIPANT* *BIRTHDATE*

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*STREET ADDRESS* *CITY, STATE & ZIP CODE*

The protected health information that you authorize to be used for research purposes may include some or all of your health records, including, but are not limited to: hospital records and reports; admission history, and physical; X-ray films and reports; operative reports; laboratory reports; treatment and test results; immunizations; allergy reports; prescriptions; consultations; clinic notes; and any other medical records needed by the **Research Team**.

*I understand that this release also pertains to medical records concerning hospitalization or treatment, including but not limited to, information regarding treatment for alcohol/substance abuse, human immunodeficiency virus (HIV), or for psychiatric treatment or counseling. I have the right to specifically request that the below records NOT be released from my health care providers to the research team, however, I understand that if I limit access to any of the records listed below, I may not be able to be in this research study. Limitations, if any:*

- |  |  |
|--|--|
| <input type="checkbox"/> Mental health records | <input type="checkbox"/> Sexually transmitted diseases |
| <input type="checkbox"/> Psychotherapy Notes   | <input type="checkbox"/> Alcohol / Substance abuse     |
| <input type="checkbox"/> HIV (AIDS)            | <input type="checkbox"/> Other: _____                  |

**You authorize the following persons, groups or organizations to disclose the information described in this Release of Information/Authorization for the above named research study:**

Treating physicians and healthcare providers, their staff, associated healthcare institutions and hospitals where care has or will be provided.

The persons, groups or organizations listed above may share my PHI (or the PHI of the individual(s) whom I have the authority to represent), with the following persons or groups (i.e. Research Team):

Dr. Conneally, his research team and associates, and regulatory agencies (e.g. study sponsor and IRB).

**Expiration date of this Authorization:** This authorization is valid until the following date or event: Date \_\_\_\_\_; End of the Study \_\_\_\_\_; None \_\_\_\_\_;

x Other: Indefinitely or until such time as legal requirements will allow them to be destroyed.

