**Project Title:**

**The federal and state governments have issued a privacy rule to protect the privacy rights of individuals enrolled in research. The privacy rule is designed to protect the confidentiality of an individual’s health information. This describes your rights and explains how your health information will be used and disclosed for this study.**

# PURPOSE

You are being invited to participate voluntarily in the above-titled research project. The purpose of collecting Protected Health Information (PHI) for this study is help researchers answer the questions that are being asked in this research study.

**WHAT INFORMATION MAY BE USED AND GIVEN TO OTHERS?**

Information that will be collected about you includes:

**WHO MAY USE AND RECEIVE INFORMATION ABOUT ME?**

Information about you may be given out by the Principal Investigator and study personnel to:

* Representatives of regulatory agencies (including Sonoran IRB) to ensure quality of data and study conduct.

**WHY WILL THIS INFORMATION BE USED AND/OR GIVEN TO OTHERS?**

This information will be used to …..

The results of this research may be published in scientific journals or presented at professional meetings, but your identity will not be revealed.

**HOW LONG WILL THIS INFORMATION BE USED AND/OR GIVEN TO OTHERS?**

Your PHI will be linked to your identifying information for …... After this time, all links will be destroyed, and your identity will not be able to be determined.

This authorization will expire on the date the research study ends.

**MAY I REVIEW OR COPY THE INFORMATION OBTAINED FROM ME OR CREATED ABOUT ME?**

You have the right to access your PHI that may be created during this study as it relates to your treatment or payment. Your access to this information will become available only after the study analyses are

**MAY I WITHDRAW OR REVOKE (CANCEL) MY PERMISSION?**

You may withdraw this authorization at any time by notifying the Principal Investigator in writing. If you choose to withdraw your authorization, any information previously disclosed cannot be withdrawn and may continue to be used. The address for the Principal Investigator is …

**WHAT IF I DECIDE NOT TO GIVE PERMISSION TO USE AND GIVE OUT MY HEALTH INFORMATION?**

You may refuse to sign this authorization form. If you choose not to sign this form, you cannot participate in the research study. Refusing to sign will not affect your present or future medical care.

**IS MY HEALTH INFORMATION PROTECTED AFTER IT HAS BEEN GIVEN TO OTHERS?**

Once information about you is disclosed in accordance with this authorization, the individual or organization that receives this may redisclose it and your information may no longer be protected by Federal Privacy Regulations.

**CONTACTS**

You can obtain further information from the Principal Investigator, …at…. If you have questions concerning your rights as a research subject, you may call the Sonoran IRB office at (480) 222-9361 or via email at j.bain@sonoran.edu.

**AUTHORIZATION**

I hereby authorize the use and disclosure of my individually identifiable health information. I will be given a copy of this signed authorization form.

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Subject’s Signature Date

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Printed Name of Subject

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Signature of Subject’s Legal Representative (if necessary) Date

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Printed Name of Subject’s Legal Representative

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Relationship to the Subject