UHealth
UNIVERSITY OF MIAMI HEALTH SYSTEM

UNIVERSITY OF MIAMI
MILLER SCHOOL
of MEDICINE

**Authorization for Release of Individually Identifiable Health Information for Research Pre-Screening**

**Authorization to Use or Disclose (Release) Health Information that Identifies You for Possible Participation in a Research Study**

**(THIS IS NOT AN INFORMED CONSENT)**

Patient Name:_____

Date of Birth: _____

Phone Number: _____

Treatment Dates: _____

If you sign this document, you, _____ *(insert patient name)*, give permission to the University of Miami and their respective trustees, officers, employees, agents and servants, including but not limited to all clinicians involved in your care at University of Miami to use or disclose (release) your health information that identifies you for possible participation (recruitment) in the research study described below *(insert name and/or brief description of study)*:

The health information that we may use or disclose (release) for this purpose includes demographic and diagnosis information to determine recruitment possibilities *(patient name; address; phone number; diagnosis; health information in my medical records pertaining to HIV status, including my HIV test results [if applicable])*:

The health information listed above may be used by and/or disclosed (released) to *(insert name of Principal Investigator or study recruitment contact)* and their research study personnel members:

The University of Miami is required by law to protect your health information. By signing this document, you authorize the University of Miami to use and/or disclose (release) your health information for recruitment for this research study. Those persons who receive your health information (the research study staff) may not be required by federal privacy laws (such as the HIPAA privacy rule) to protect it and may share your information with others without your permission, if permitted by applicable law.

Please note that:

- You do not have to sign this Authorization, but if you do not, we will not provide your contact information and identifiable protected health information, which may include your medical condition, to the research study staff. If you do not sign this Authorization, your right to other medical treatment at the University of Miami will not be affected.

- You may change your mind and revoke (take back) this Authorization at any time, except to the extent that the University of Miami has already acted based on this Authorization. If the University of Miami has not yet released your contact or other health information to the research study staff, your revocation will be effective for all information releases described in this Authorization.

- If the University of Miami or research study staff has acted in reliance on this Authorization, they may still use or disclose health information they already have obtained about you prior to your revocation of the Authorization. The University of Miami has acted in reliance on this Authorization if, prior to the date of revocation, the University of Miami has forwarded your contact information or other health information to the research study staff.

- To revoke this Authorization, you must write to the Research Study personnel listed below:

  **Research Study Personnel Name:** _____

  **Address:** _____

  **Phone:** _____

**Research Study personnel must forward a copy of any revocation to the Human Subjects Research Office (HSRO) and Office of HIPAA Privacy & Security (OHPS)**

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| Human Subjects Research Office<br>JMT East 1002 (M-809)<br>(305) 243-3195 | Office of HIPAA Privacy & Security<br>PAC 409 (M-879)<br>(305) 243-5000 |

- This form does not constitute an informed consent. Should you be considered eligible to participate in this study, you will be asked to sign an informed consent.
- You will be given a copy of this Authorization after you have signed it, and a copy will be placed in your medical record.
- If not revoked earlier, this Authorization automatically expires one year from date signed or upon the end of the research study.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

I understand that some of the persons or entities that may receive the information described above are not health care providers or health plans covered by federal privacy regulations, and therefore, the information may be redisclosed and no longer protected by these regulations.

**Referring personnel must place the signed form in the patient's medical record and study personnel must send copy to the office of HIPAA Privacy & Security for scanning.**

_____ _____
Signature of patient of patient's legal representative Date

_____
Printed name of patient or patient's legal representative

_____
If applicable, a description of the personal representative's authority to sign for the participant

_____ _____
Interpreter's Signature Date

_____
Printed name of Interpreter