UNIVERSITY OF MISSOURI-COLUMBIA
Institutional Review Board

HIPAA AUTHORIZATION FORM

Authorization for the Use and Disclosure of Personal Health Information Resulting from Participation in a Research Study

Project Title: Customized Health Alerts and Consumer-Centered Interfaces Using In-Home and Wearable Sensors
Principal Investigator's Name: Marjorie Skubic
Project # 2009010

Purpose:
State and federal privacy laws protect the use and release of your health information. If you decide to give your permission to participate in the study listed above, you must sign this form as well as the Consent Form. This form describes the different ways that the researcher, the study team and the sponsor may use your health information for the research study. Signing this authorization is completely voluntary.

1. Description of your Protected Health Information that is to be used:
My authorization applies to the information described below. **By law**, the information must be limited to the minimum necessary information needed to accomplish the purpose of the research.

- ☒ Name
- ☐ Radiology Images
- ☐ Radiology Imaging Reports
- ☐ EKG
- ☒ Progress notes
- ☒ History and Physical exams
- ☐ Operative Reports
- ☐ Pathology Reports
- ☐ Laboratory Reports
- ☐ Photographs and or Videotapes
- ☒ Contact information such as address, phone number
- ☒ Discharge Summaries
- ☐ Health Care Billing or Financial Records
- ☒ Consultations
- ☒ Medications
- ☒ Emergency Medicine reports
- ☐ Dental Records
- ☒ Demographic information such as age, race etc.
- ☒ Questionnaires, Surveys and/or Subject Diaries
- ☐ Audiotapes
- ☐ Other (please list) _____

_____

2. Permission for certain specific uses:
If any of the following information will be released **you must initial to give your permission**:
____ I agree to release of information pertaining to drug and alcohol abuse, diagnosis or treatment
____ I agree to release of information of HIV/AIDS testing information
____ I agree to release of genetic testing information
____ I agree to release of information pertaining to mental health diagnosis or treatment as follows:
_____

3. Who may receive your information?
The primary investigator listed at the top and the study team may use and/or disclose your information to the following person(s) or class of persons:
Compliance and Safety Monitors, the MU Health Sciences Institutional Review Board, Government agencies, the sponsor (insert name below)
☒ Other: National Institutes of Health

_____

IRB USE ONLY
Acknowledged Date: December 12, 2017

4. Purpose of the use or disclosure

My PHI will be used and/or disclosed upon request for the following purposes:
Publications and presentation that will not identify me, auditing, administrative and billing reviews, study outcomes including safety and efficacy

**If applicable add the following information as well:*

☐ My treatment during the study
☐ Submission to the government agencies that may monitor the study
☐ *Describe any other disclosure*_____

5. Expiration date or event

Unless you revoke (take back) your authorization, your authorization will allow us to use and/or disclose your information will

☒ Expire at the end of research study
☐ There will be no expiration date (for example when creating a database)
☐ Other: _____

_____

6. Your right to revoke or withdraw authorization

I understand that I have a right to revoke this authorization at any time. My revocation must be in writing in a letter sent to the Principal Investigator, Dr. Marjorie Skubic at The MU Department of Computer and Electrical Engineering, 329 Naka Hall, University of Missouri, MO 65211. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my PHI have already acted in reliance upon this authorization.

7. Statement that re-disclosures are no longer protected by the HIPAA Privacy Rule

I understand that my personal health information will only be used as described in this authorization in relation to the research study. I am also aware that if I choose to share the information defined in this authorization to anyone not directly related to this research project, the law would no longer protect this information. In addition, I understand that if my personal health information is disclosed to someone who is not required to comply with privacy protections under the law, then such information may be re-disclosed and would no longer be protected.

8. Right to refuse to sign authorization and ability to condition treatment, payment, enrollment or eligibility for benefits for research related treatment

I understand that I have a right not to authorize the use and/or disclosure of my personal health information. In such a case I would choose not to sign this authorization document I understand I will not be able to participate in a research study if I do not do so. I also understand that treatment that is part of the research project will be conditioned upon my authorization for the use and/or disclosure of my personal health information to and for use by the research team.

9. Suspension of right to access personal health information

I agree that I will not have a right to access my personal health information obtained or created in the course of the research project until the end of the study.

10. If I have not already received a copy of the University of Missouri Healthcare Privacy Notice, I may request one. If I have any questions or concerns about my privacy rights I should contact, the HS Privacy Officer at 573-882-9054 or the Campus Privacy Officer at 573-882-9500.

11. Individuals' signature and date

I certify that I have received a copy of the authorization.

_____ _____

Signature of Research Participant Date

_____

Research Participant's Legally Authorized Representative Date

_____

Describe Representative Authority to Act for the Participant

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