



Oregon Health & Science University
Hospitals and Clinics
OHSU News and Publications
 3181 SW Sam Jackson Park Rd,
 Mailcode L217
 Portland, OR 97239-3098
 (503) 494-8231, Fax (503) 494-8246

ACCOUNT NO.
 MED. REC. NO.
 NAME
 BIRTHDATE

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

ALL SECTIONS OF THE AUTHORIZATION **MUST** BE COMPLETED OR THE AUTHORIZATION WILL NOT BE ACCEPTED.

I authorize OHSU to use and disclose a copy of the specific health information described below regarding: _____ (Name of individual)

consisting of: _____ My name _____ My age _____ My city, county or state residence _____ Information about my specific injuries _____ An interview with me at OHSU _____ A photograph of me at OHSU _____ Videotape of me at OHSU _____ Other information as described here: _____
 to OHSU for the purpose of: _____ Media request (_____ all media _____ specified media _____)
 _____ OHSU Advertisement _____ OHSU Brochure _____ OHSU Annual report _____ OHSU Magazine _____ OHSU Newsletter _____ OHSU Marketing campaign _____ OHSU Fund-raising campaign _____ OHSU World Wide Web site
 ___X___ Other. Title of project : **Doernbecher Imaging Project Education Registry.**

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed only if I place my **initials** in the applicable space next to the type of information.

_____ HIV/AIDS information
 _____ Mental health information
 _____ Genetic testing information
 _____ Drug/alcohol diagnosis, treatment, or referral information

Diagnosis:

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign will mean you will not receive health services is if the health services are solely for the purpose of providing health information to someone else, and the authorization is necessary to make that disclosure. Your refusal to sign this authorization does not adversely affect your enrollment in a health plan or eligibility for health benefits, unless the authorized information is necessary to determine if you are eligible to enroll in the health plan.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any uses or disclosures already made with your permission cannot be undone.

To revoke this authorization, please send a written statement to Med. Correspondence, Health Information Services, OP17A, OHSU 3181 SW Sam Jackson Pk Rd. Portland, OR 97239-3098, and state that you are revoking this authorization.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic information and drug/alcohol diagnosis, treatment or referral information.

I have read this authorization and I understand it.

Unless revoked, this authorization expires _____ (insert applicable date or event).

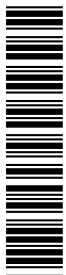
By: _____ Date: _____
 (Signature of individual or personal representative)

Description of personal representative's authority: _____

ONLINE 4/2003

For TML use only: Reference #
 Tape # Time code:
 Received by:

MR-4650





HIPAA RESEARCH AUTHORIZATION

**Authorization for the Creation, Use, and Disclosure of Protected Health Information
for Institutional Review Board Approved Research**

Instructions: This authorization should be attached to each Consent Form. Investigators please complete information fields below and questions 2-9. Leave subject name and signature areas blank.

Title of Study: Doernbecher Imaging Project Education Registry
Name of Investigator: Dana Braner, MD
Phone Number: 503-418-5885
Sponsor: _____
IRB Number: _____
Protocol Approval Date: _____
Consent Form Approval Date: _____

This form authorizes Oregon Health & Science University (OHSU) to use and disclose certain protected health information about _____
that we will collect and create in this research study. (Name of research subject)

This authorization is voluntary, and you may refuse to sign this authorization. If you refuse to sign this authorization, your health care and relationship with OHSU will not be affected, however, you will not be able to enter this research study.

1. If you sign this form, you are agreeing that OHSU may use and disclose protected health information collected and created in this research study.
2. The specific health information and purpose of each use and disclosure are:

- NA Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection information
- NA Drug/alcohol diagnosis, treatment, or referral information
- NA Mental or behavioral health or psychiatric care
- NA Genetic testing information

4. The persons who are authorized to use and disclose this information outside of OHSU are:

- All investigators listed on page one of the Research Consent Form
- Others at OHSU who are participating in the conduct of this research protocol
- The OHSU Institutional Review Board
- Others: Media Lab at Doernbecher

5. The persons who are authorized to receive this information are:

- The sponsor of this study: _____
- Federal or other governmental agencies responsible for research oversight: _____
- Others: Media Lab at Doernbecher

6. Protected health information that we collect from you in this study will be kept by us until:

- HIPAA Research Authorization expiration date _____

-OR-
- The study is completed _____
- Indefinitely
- Other: _____

7. While this study is still in progress, you may not be given access to medical information about you that is related to the study. After the study is completed and the results have been analyzed, you will be permitted access to any medical information collected about you in the study. If this study has not collected any medical information about you, you will be advised of that.

8. You have the right to revoke this authorization and can withdraw your permission for us to use your information for this research by sending a written request to the Principal Investigator listed on page one of the research consent form. If you do send a letter to the Principal Investigator, the use and disclosure of your protected health information will stop as of the date he/she receives your request. However, the Principal Investigator is allowed to use information collected before the date of the letter or collected in good faith before your letter arrives. Revoking this authorization will not affect your health care or your relationship with OHSU.

9. The information about you that is used or disclosed in this study may be re-disclosed and no longer protected under federal law. However, federal or state law may restrict re-disclosure of HIV/AIDS information; mental health information; genetic information; and drug/alcohol diagnosis, treatment, or referral information. OHSU tries to protect against re-disclosure without your permission by being very careful in

releasing your information. The ways in which we will limit the further release of your protected health information are:

- Contractual agreements with those who may receive the information
- Not releasing your information in a way that could identify you
- Other:

You will receive a copy of this authorization form after you sign it.

Printed name of Research Subject

Signature of Subject

Date

-OR-

Printed name of Subject's Legally Authorized Representative

Signature of Subject's Legally Authorized Representative

Date

Description of Relationship to Subject: _____

The OHSU Research authorization form must be used exactly as it is presented here. Any alteration or editing of the form will render it unapproved for research use at OHSU. The use of an unapproved research consent/authorization form will require that any data collected from subjects who received such a form, must be excluded.