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| **Department of Veterans Affairs** | **VA HIPAA AUTHORIZATION FORM** DR Nov 2013 |
|  | Subject Name: |       | **Date** |       |  |
|  | **Title of Study:** |  |  |
|  | **Principal Investigator:** |  | **VAMC:** | Madison, WI |  |
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| Authorization for Release of Protected Health Information for a Data RepositoryYou have been invited to be part of a research data repository under the direction of **[the Repository Director]**. The information collected will be retained in a data repository that will be comprised of **[tissue and serum specimens, and associated clinical data][data]** that may be used for future research in the following area(s): **[list potential research areas]**. By signing this document, you authorize the Veterans Health Administration (VHA), **[Repository Director]** and future Research teams to use and disclose the following information about you **[list all medical and identifying information collected- please be specific]**. **[If any 7332 information will be used in your repository the appropriate type should be marked from the list below. If none of this information will be used, please delete this language.]**The information that will be used or disclosed includes the following conditions: \_\_\_\_ Drug Abuse \_\_\_\_ Alcohol Abuse \_\_\_\_ Testing for or Infection with Human Immunodeficiency Virus (HIV) \_\_\_\_ Sickle Cell AnemiaThe Repository Director may also need to disclose the information to others as part of the review process. This will include the Department of Veterans Affairs and research oversight boards and offices at the University of Wisconsin and the Madison VA. Others who may need access to the information include: **[Annotate anyone else including non-VA analysts, sponsors, oversight groups, etc. who may have access to the information]**.  There is no expiration date for this authorization. If you do not sign this authorization, you will not participate in the data repository. Treatment, payment, enrollment, or eligibility for benefits cannot be conditioned on your completion of the authorization. |

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| SUBJECTS IDENTIFICATION *(I.D. plate or give name-late, first, middle)*  Subject Initials \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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|  Authorization for Release of Protected Health Information for a Data Repository Page 2You can revoke this authorization, in writing, at any time, except to the extent that the Repository Director has acted in reliance on it. To revoke your authorization, you should write to the Release of Information Office at this facility (William S. Middleton Memorial Veterans Hospital, Room A-28, mail stop 136, 2500 Overlook Terrace, Madison, WI 53705) or you can ask the Repository Director to give you a form to revoke the authorization. Your request will be valid when the Release of Information Office receives it. If you revoke this authorization you will not be able to continue to participate in the repository. If you revoke this authorization, no health information will be shared with researchers after that time. Information that was shared prior to the revocation will continue to be used. The VHA complies with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its privacy regulations and all other applicable laws that protect your privacy. We will protect your information according to these laws. Despite these protections, there is a possibility that your information could be used or disclosed in a way that it will no longer be protected. Individually-identifiable health information [IIHI] disclosed pursuant to this authorization may no longer be protected by Federal laws or regulations and may be subject to re-disclosure by the recipient. Our Notice of Privacy Practices (found at <http://www.va.gov/vhapublications/viewpublication.asp?pub_id=1090>) provides more information on how we protect your information. If you do not have a copy of the Notice, the research team can provide one for you.I have read this authorization form and have been given the opportunity to ask questions. If I have questions later, I can contact Dr. [XXX] at [xxx-xxxx]. I will be given a signed copy of this authorization form for my records. I authorize the use of my identifiable information as described in this form. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature of Participant or Person Authorized DateTo Sign for Participant (Attach authority to sign, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_e.g., Power of Attorney) Social Security # last 4 digits  |

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