USC HIPAA AUTHORIZATION
TO USE HEALTH INFORMATION FOR RESEARCH

1. **Purpose of this Form:**

A federal law known as the Health Insurance Portability and Accountability Act (HIPAA) protects how your health information is used. HIPAA does not allow your health information to be used or released for certain purposes without your written permission. Health information protected under the law includes: medical and dental records, bills or other payment records for health care received, tissue samples, x-rays, laboratory results and other health information that identifies you. State laws also protect how your health information may be used.

By signing this form, you are allowing your health care providers (for example, physicians, dentists, hospitals, clinics) to release your health information to the researchers and others involved in this research study for the uses described below and also described in the informed consent.

You will be given a signed copy of this authorization.

2. **Healthcare Providers Covered by this Authorization:**

This authorization permits the following healthcare providers to release your health information for the research purposes described in this document:

(Check **ALL** boxes that apply)

- [x] The researcher/clinician generating health information through this study
- [ ] All health care providers with health information about me
- [ ] USC Norris Cancer Hospital
- [ ] Keck Hospital of USC
- [ ] Children’s Hospital Los Angeles
- [ ] LAC+USC Medical Center
- [ ] Keck Doctors of USC
- [ ] Herman Ostrow School of Dentistry
- [ ] Other: __________________________________________(please specify)
3. **Health Information Covered by this Authorization:**

The health care providers listed above are authorized to release the following health information about you:

**[PLEASE CHECK ONE OF THE TWO BOXES BELOW]**

- ✓ All health information that is created during the research study; **AND**
- □ All of your health information that the health care provider has in his or her possession, including information relating to your mental or physical condition and any treatment you received, except for HIV test results, certain mental health records, and drug or alcohol treatment records;

**OR**

- □ Only the following records or types of health information:

(Insert dates of treatment or specific types of treatment, records or reports.)

**[THE FOLLOWING INFORMATION ONLY WILL BE RELEASED IF YOU GIVE SPECIFIC PERMISSION BY INITIALIZING ON THE LINE(S) BELOW]**

- □ _______ HIV test results
- □ _______ Mental health treatment records
- □ _______ Drug and alcohol treatment records

4. **How Your Health Information Will Be Used:**

Your health information may be released to the following individuals or entities for the following purposes:

- Researchers (those individuals in charge of the study), research staff, students and the research sponsor and its representatives for purposes of conducting the research study as described in the informed consent and other research activities related to this study, such as conducting safety analyses.

- The USC Institutional Review Boards (IRB), USC Contract Research Organization (USC CRO), USC Office of Compliance, U.S. government agencies, such as Food and Drug Administration and the Office for Human Research Protections, international government agencies and others who are authorized by law to review or oversee this research.
Principal Investigator: Kyle Cologne M.D.
Study Title: Patient volunteers greatly advance surgical knowledge when they donate blood, tissue and health information to scientific research.
IRB #: HS-11-00563

5. **Use of Health Information in a Research Database:**

Researchers will often review existing health information from large groups of patients in order to test or validate theories that the researcher develops.

☐ By checking this box, you allow the USC research team (USC researchers, staff and students) to put your health information in a database for future research purposes. However, your health information will not be used or released for future research without your written permission or unless specifically required or permitted by law.

This section of the Authorization will remain in effect indefinitely from the date of this Authorization, unless you revoke (withdraw) this authorization as described below.

6. **Scope of this Authorization:**

The USC research team may only use and release your health information for the purposes described in this authorization or as otherwise permitted by law. However, health information that is shared with others outside USC may not be protected by HIPAA once it is released. For example, the sponsor of this research may use your information for future research studies. Certain health information may still be protected under state law.

7. **Right to Deny Access to Health Information:**

You may not be permitted to access (review or copy) the health information created during this research study while the research study is in progress. You may be entitled to access this health information once the research study is completed.

8. **Term of this Authorization:**

Except for database research, this authorization expires 20 years from the date of your signature unless you revoke (withdraw) this authorization as described below.
Refusal to sign/Right to Revoke:

You must sign this Authorization in order to participate in this research. You may change your mind and revoke (withdraw or cancel) this authorization and your participation in this research study at any time. To do so, your revocation (withdrawal or cancellation) must be sent in writing to the Principal Investigator and include: (1) the title of the research study; and (2) your name and telephone number or address. Please send the revocation to the following:

Kyle Cologne, MD
USC Norris Cancer Center
1441 Eastlake Avenue
Los Angeles, CA 90033
323-865-3690

You will not be allowed to participate in the research and we will stop collecting your health information as of the date the Principal Investigator receives your revocation. However, we may still use and share your health information already obtained as necessary to maintain the integrity of the research study.

Questions regarding your privacy rights:

Please contact the USC Office of Compliance by telephone at 213-740-8258 or email at complian@usc.edu if you have questions about your privacy rights.

Agreement:

I have read (or someone has read to me) the information provided above. I have been given the opportunity to ask questions and all of my questions have been answered to my satisfaction. By signing below, I agree that my health information may be used as described in this form.

Name of Participant                      Signature                      Date Signed

If Individual is unable to sign this Authorization, please complete the information below:

Name of Legal Guardian/Personal Representative  Signature  Legal Relationship  Date Signed

Rev. 11.1.11