

## **AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION**

I agree to permit (Principal Investigator) and his staff (together “Researchers”) as well as Providence Hospital and Medical Centers (and the study sponsor, its agents and contractors) to use and disclose health information that identifies me for the purposes described below. I also agree to permit Providence Hospital and Medical Centers, my doctors, and my other health care providers to disclose health information in my medical records to the Researchers and to (the Sponsor) for the purposes described below:

1. The health information that may be used and disclosed includes:
  - all information collected during the research described in the Informed Consent Form; and
  - health information in my medical records that is relevant to the research described in the Informed Consent Form.
2. The Researchers may:
  - use and share my health information to conduct the research;
  - disclose my health information to Providence Hospital and Medical Centers (and the Sponsor)
  - disclose my health information as required by law and to representatives of government organizations, review boards, and other persons who are required to watch over the safety and effectiveness of medical products and therapies and the conduct of research; and
  - remove from my health information my name and any other information that could be used to identify me
3. Providence Hospital and Medical Centers (and the Sponsor of the Study) may:
  - use and share my health information to conduct the research;
  - use my health information as described in the Informed Consent;
  - disclose my health information as required by law and to representatives of government organizations, review boards, and other persons who are required to watch over the safety and effectiveness of medical products and therapies, and the conduct of research; and
  - remove from my health information my name and other information that could be used to identify me.
4. Once information that could be used to identify me has been removed, the information that remains is no longer subject to this Authorization and may be used and disclosed by the Research and Providence Hospital and Medical Centers (and the Sponsor of the study) as permitted by law.

5. Once my health information has been disclosed to a third party, federal privacy laws may no longer protect it from further disclosure. However, the Researchers and Providence Hospital and Medical Centers (and the Sponsor of the study) agree to protect my health information by using and disclosing it only as permitted by me in this Authorization and the Informed Consent. Also, no publication about the research will reveal my identity without my specific written permission. These limitations continue even if I revoke (take back) this Authorization.
  
6. Please Note that:
  - You do not have to sign this Authorization, but if you do not, you may not be allowed to participate in the research.
  - You may change your mind and revoke this authorization at any time. To revoke this Authorization, you must write to (the Principal Investigator). However, if you revoke this Authorization, you may no longer be allowed to participate in the research. Also, even if you revoke this Authorization, the information already obtained by the Researchers and Providence Hospital and Medical Centers (and the Sponsor of the study) may be used and disclosed as permitted by this Authorization and the Informed Consent.
  
7. This Authorization does not have an expiration (ending) date.
  
8. You will be given a copy of this Authorization after you have signed it.

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Signature of participant or participant's legal representative

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Date

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Printed Name of participant or participant's legal representative

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Date