

**ST. VINCENT
AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION FOR
RESEARCH PURPOSES**

A new privacy rule has been issued to protect the privacy rights of patients. This rule was issued under a law called the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Privacy Rule is designed to protect the confidentiality of your health information. This document explains how your health information will be used and disclosed for the purposes of conducting, monitoring and auditing this study and describes your rights with respect to that information.

Your personal health information is information about you that could be used to identify you, such as your name, address, telephone number, photograph, date of birth, social security number, new and existing medical records, blood or DNA samples, or the types, dates and results of various tests and procedures. This may include information in your medical and hospital records, as well as information created or collected during the study.

By signing this document you authorize the study physicians (Researchers), St. Vincent Hospital and employees (Researchers) to use and disclose the following information about you to each other, the study sponsor and its representatives, the St. Vincent Hospital Institutional Review Board, and governmental agencies responsible for the oversight of this study including the Food and Drug Administration and any foreign agencies as necessary: personal health information in your medical and hospital record including medical/surgical history, past and current medications, vital signs, physical examinations and laboratory results, other assessments, photographs and samples and analyses of blood, DNA and/or wounds. Your personal health information will be used to conduct the research study as described in the Informed Consent.

If results of this study are published or reported in medical journals or at meetings, your name will not be included.

St. Vincent Hospital will not condition treatment or payment on whether or not you sign this document. However, this document is required if you want to participate in the study.

You may revoke this document in writing at any time by writing to the St. Vincent Hospital Research Department at 8402 Harcourt Road, Suite 208, Indianapolis, Indiana 46260. You understand that if St. Vincent Hospital has already taken action in reliance on your authorization they do not have to undo that action. Once your authorization has been revoked you will no longer be able to participate in the study.

Once information is disclosed, it can no longer be controlled by the study physician, St. Vincent Hospital or by you and may be re-disclosed by the recipient. Thus, your information would no longer be protected by the Privacy Rule.

A copy of this document will be placed in your medical record and you will receive a copy.

Your authorization to disclose your personal health information as described in this section will expire at the end of this study, after all study related data has been transferred to the sponsor.

You will not be allowed to review the information collected for the Study until after the study is completed. When the study is over you will have access to the information again.

By signing this document, you acknowledge that you have read and understand this Authorization. Further, you authorize Researcher to use or disclose your health information in accordance with the terms of this Authorization.

Title of Study:

Sponsor:

Printed name of subject

R

R-number of study

Signature of subject/ authorized legal representative

Date

Relationship of authorized legal representative to subject