

**Genesys Health System
HIPAA FORM
Patient Authorization to Use and Disclose
Protected Health Information for Research Purposes**

Patient's Name: _____

Patient ID Number: _____

I. Policy Statement.

We know that information about you and your health is private, and we are committed to protecting the privacy of that information. Because of this commitment, we must get your special permission before we may use or share your protected health information (“**PHI**”) for the research purposes described below. This form gives us that permission and helps us make sure that you are properly informed of how your PHI will be used or shared. Please read the information below carefully before signing this form.

II. Authorization/Purpose.

As a research participant, I hereby allow my individual physicians and Genesys Health System (“**GHS**”) and its researcher staff, including the Principal Investigator, to use and share my PHI as needed for the following research project:

- A. Name of Research Project (“**Research Study**”):
- B. Name of Principal Investigator (“**PI**”):

III. People Who May Get My Health Information:

The PHI shared by GHS may be used by the following parties:

- Every research site for this Research Study, including Genesys Regional Medical Center (“**GRMC**”), including each site's research staff and medical staff.
- Every health care provider who gives services to me for this Research Study.
- Any laboratories and other persons and organizations that look at my PHI in connection with this Research Study according to the Research Study's guidelines.
- The United States Food and Drug Administration, Centers for Medicare & Medicaid Services, Notified Bodies, Competent Authorities and other regulatory agencies.
- The members and staff of Genesys Regional Medical Centers Institutional Review Board.
- All doctors involved in the Research Study
- Members of the Research Team.
- Members of the hospital's administrative staff who are in charge of clinical trials and other research activities.
- Others (as described below):

IV. Individual Health Information to be Used or Disclosed:

My PHI that may be used or shared to carry out the Research Study includes:

- All health information, including my entire research record and any medical records held by GHS or its operating units.
- The results of tests or procedures done as part of the Research Study and any and all information resulting from my involvement in the Research Study.
- Other (as described below)

The health information to be used or shared as agreed to by this Authorization may ___ may not ___ include medical records regarding alcohol and drug abuse treatment, psychological or psychiatric treatment, social services, counseling, HIV, AIDS or AIDS related complex, communicable diseases and infections, venereal disease, hepatitis and tuberculosis.

V. Expiration

- This Authorization will expire on: _____
- This Authorization will expire at the end of the Research Study.

VI. Right to Refuse to Sign this. I have the right to refuse to sign this. GHS will not change treatment, payment, enrollment or eligibility for benefits on whether I sign this. If I decide not to sign this, I may not be able to be in this Research Study or get any research related treatment provided by the Research Study. If I do not sign this form I will still get any health care treatment and/or benefits to which I am otherwise entitled.

VII. Right to Change My Mind. I have the right to cancel my permission to use my PHI at any time. If I cancel my permission, the Principal Investigator may not be able to take out all of the information that has already been used or shared with others to carry out the research, but no new information will be collected or shared. My written cancellation must be sent to the Genesys Research Office at the following address:

Genesys Office of Research
One Genesys Parkway, Suite 2442
Grand Blanc, MI 48439
810-606-7722

VIII. Potential for Re-Disclosure. When my information is used or shared pursuant to this Authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule.

By signing this Authorization, I acknowledge that I have read and understand this Authorization. I will be given a copy of this signed Authorization form.

Copy of Authorization must be given to patient or personal representative.

Participant's Name: Signature

Print Name:

Date:

Legal representative: Signature

Print Name:

Date:

(Legally authorized to act as personal representative)