Authorization for Use or Disclosure of Protected Health Information for Research
(For Use With Short Form Consent)

Name: _____ Subject Number or Date of Birth: _____

I hereby authorize Yale University to use or disclose my protected health information as indicated below for the purpose of participation in a research study (to be completed by study staff)**:**

Study Title: _____

HIC/HSC Protocol #: _____ Study PI: _____

Information to be released for time period of _____ to _____:

- ❑ Research record
- ❑ History and physical exam
- ❑ Immunizations
- ❑ Lab report
- ❑ X-ray report
- ❑ Consultation report/notes
- ❑ Prescription Information
- ❑ Notes and test results related to: _____
- ❑ Other/Comments: _____

I understand that this health information may include sensitive information. By signing this form I am specifically authorizing the release of information relating to:

- ❑ Substance Abuse Treatment information
- ❑ HIV related information, including AIDS related testing
- ❑ Mental Health Information

Signature _____
Date: _____

The confidentiality of this record is required under Chapter 899 of the Connecticut General Statutes as well as Title 42 of the United States code. This material shall not be transmitted to anyone without written consent or authorization as provided in these statutes.

Records may be used by and disclosed to any of the following:

- ☐ The U.S. Department of Health and Human Services (DHHS) agencies
- ☐ Representatives from Yale University, the Yale Human Research Protection Program any external Institutional Review Boards reviewing on behalf of Yale and those responsible for research and financial oversight
- ☐ Those providers who are participants in the Electronic Medical Record (EMR) system
- ☐ The Principal Investigator and research team
- ☐ The U.S. Food and Drug Administration (FDA)
- ☐ The study sponsor or manufacturer of study drug/device
- ☐ Drug regulatory agencies in other countries
- ☐ Health care providers who provide services to you in connection with this study.
- ☐ Laboratories and other individuals and organizations that analyze your health information in connection with this study, according to the study plan.
- ☐ Data and Safety Monitoring Boards/Committees and others authorized to monitor the conduct of the Study
- ☐ Others as noted: _____

1. I understand that this authorization will expire after _____years/never. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying the study Principal Investigator or research team and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it. I may also send revocation to: HIPAA Privacy Officer, Yale University, PO Box 208255, New Haven, CT 06520-8255
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
4. My health care and payment for my health care will not be affected if I do not sign this form.
5. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.
6. I understand that I will get a copy of this form after I sign it.

By signing below, I acknowledge that I have read and understand this Authorization.

_____ OR _____ _____
Signature of Patient **Parent/Legal Guardian/Authorized Person** Date

_____
Relationship to Patient