***This Stand Alone HIPAA Form will be completed and submitted by the site for review.***

**Piedmont Healthcare Research Subject HIPAA Authorization Form  
for Use or Disclosure of Protected Health Information (PHI)  
(In accordance with HIPAA Act 45 CFR 160 and 164)**

Research study title:

IRBNet ID number:

**PHI disclosure purpose:**By signing this form you give us permission to use or disclose your requested PHI (itemized below) for the conduct and oversight of the above-mentioned research study.  
  
**PHI that will be Used or Disclosed:**  
⁫ Entire medical record ⁫ Abstract of Record\* ⁫ Financial Record   
⁫ Radiology Films ⁫ Data created during the study ⁫ Pathology Slides/Blocks  
⁫ Diagnostic Photos, specify:   
⁫ Other, specify:   
\* **An abstract of the record includes: History/Physical Report, Operative, Consultation and Discharge Summary Reports, and diagnostic test results.**

The information used/disclosed pursuant to this authorization will not include psychotherapy notes, but may include detailed mental health information, HIV/AIDS information and/or information regarding alcohol or substance abuse.  
  
**People that will Use or Disclose your PHI:** (the following person(s), class(es) of persons, and/or organization(s) who may disclose, use , and receive the information, but they may only use and disclose the information to the other parties on this list, to the research subject or his/her personal representative, or as otherwise permitted or required by law.

* The Principal Investigator and the research staff and any other people and groups authorized to help conduct the study.
* , the study sponsor for this research study. The sponsor may also use your PHI to collect and analyze the results of the research and may have other people and groups help conduct, oversee, and analyze the study. These people will use your PHI.
* Every health care provider who provides services to you in connection with this study.
* Anyone who has access to your medical records.
* Any laboratories and other individuals and organizations that analyze your health information in connection with this study in accordance with the study’s protocol.
* The Institutional Review Board and the Office of Research Services.
* Any government agencies that regulate research including: the Office for Human Research Protections, The Food and Drug Administration, Medicare, Medicaid, and other regulatory agencies.
* Data and Safety Monitoring Boards / Ethics Committees, research monitors and reviewers.
* Others, specify:

**Revoking your Authorization:**You do not have to sign this authorization form. If you do not sign, you may not participate in the above-mentioned research study. Piedmont providers shall not condition treatment on the receipt of this authorization and you may still get non-research related treatment. You may even sign and at any later time revoke this Authorization. If you do wish to revoke authorization you must write to:   
After that point, the researchers would not collect any more of your PHI. But they may use or pass along the information you already gave them so they can follow the law, protect your safety, or make sure the research was done properly. The information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient of the information and may then no longer be protected by the federal privacy regulations. This authorization for use and disclosure for research purposes indicated above is valid until **.**  You will be given a copy of this authorization.  
 **Authorization**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Participant or Legal Representative Print Name and relationship to patient Date Time