



INSTITUTIONAL REVIEW BOARD FOR THE PROTECTION OF HUMAN SUBJECTS IN RESEARCH

SAMPLE AUTHORIZATION LANGUAGE FOR CONSENT FORMS FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Informed consent, as required by the federal regulations for the protection of human subjects in research, 45 Code of Federal Regulations 46, is a consent to participate in the research study as a whole. The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule's authorization is for the use or disclosure of protected health information by health care entities for research purposes.

There are important differences between the Privacy Rule's requirements for individual authorization, and the Common Rule's requirements for informed consent. However, the Privacy Rule's authorization elements are compatible with the Common Rule's informed consent elements. Thus, both sets of requirements can be incorporated into a single form, which is permitted by the Privacy Rule.

In order for a consent form to also function as a valid authorization for use or disclosure of protected health information by health care entities, the following information (in bullets) must be included. (Include appropriate study-specific information where indicated by bold italics.)

- Protected health information is any personal health information that can identify you. If you decide to participate in this research study, you agree to the use or disclosure of your protected health information for the purposes explained in this consent form.
If you decide to participate in this research study, you authorize the use and/or disclosure of the following health information: State ALL health information needed for the study for name of person
If you decide to participate in this research study, you authorize the following individuals and/or representatives of the following organizations/institutions to use or disclose your health information in connection with this study: UNH Institutional Review Board (IRB), the UNH Regulatory Compliance Office, UNH Administrators. List names of all individuals or organizations/ institutions that will use and/or disclose the health information, e.g., the investigator, authorized research personnel, faculty advisor, health care provider/institution, and sponsor, if applicable.
The investigator will use your health information only as stated in this consent form and will protect the confidentiality your information as stated in this consent form.
The above-named individuals may use or disclose your protected health information until the end of the research study. At that point, the investigator will remove the identifiers from your information making it impossible to link you to the study.
If you decide to end your participation in this study, please notify the investigator. In order to withdraw this authorization, you should refer to the Notice of Privacy Practices published by each health care provider/institution that you have authorized above to disclose your health information as to the process for doing so. If you withdraw from the study, no new data about you will be collected for study purposes.
The health care providers/institutions named above cannot condition treatment, payment, enrollment or eligibility for benefits on your signature of this authorization except in a clinical research study that involves treatment.

Subject Signature

Printed Name

Date