Baby's First Years

HIPAA Form
HIPAA Clinical Research Authorization
for Non-Sponsored Research

<u>Note to Reader:</u>
THIS IS THE BABY'S FIRST YEARS HIPAA CONSENT FORM

For the purpose of the conduct of the above name study, I agree to permit the hospital, my doctors, and my other health care providers (together "Providers"), and [principal investigator] and his/her staff (together "Researchers"), to use and disclose health information about me as described below.

1. **The health information that may be used and disclosed includes:**
   All information collected during the research described in the Informed Consent Form for the above-named study ("the Research"); and health information in my medical records that is relevant to the Research.

   This may include medical history information that may be considered sensitive, including: Any medical, neurological, psychiatric, or developmental diagnoses and/or prescribed medications, including any suspected diagnoses of a depressive or anxiety disorder identified as a result of the Research.

2. **The providers may disclose health information in my medical records to:**
   The Researchers; and representatives of government agencies, review boards, and other persons who watch over the safety, effectiveness, and conduct of research.

3. **The researchers may use and share my health information:**
   Among themselves and with other participating researchers to conduct the Research; representatives of government agencies, review boards, and other persons who watch over the safety, effectiveness, and conduct of research; and as permitted by the Informed Consent Form.

4. Please note that:

- You do not have to sign this Authorization, but if you do not, you may not participate in the Research.
- You may change your mind and revoke (take back) this Authorization at any time and for any reason. To revoke this Authorization, you must write to *[contact information]*. However, if you revoke this Authorization, you will not be allowed to continue taking part in the Research. Also, even if you revoke this Authorization, the Researchers may continue to use and disclose the information they have already collected as permitted by the Informed Consent Form.
- While the Research is in progress, you may not be allowed to see your health information that is created or collected by [university].

in the course of the Research. After the Research is finished, however, you may be allowed to see this information.

5. This Authorization does not have an expiration (ending) date.

6. You will be given a copy of this Authorization after you have signed it.

Printed Name of Subject: ____________________

Signature of Subject or Legal Representative: ____________________ Date: __________

Relationship of Legal Representative to Subject (if applicable): ____________________