**INSTRUCTIONS FOR DRAFTING**

**A HIPAA COMPLIANT MEDICAL RECORD RELEASE FORM FOR RESEARCH**

The purpose of this form is to have the participant identify those health providers from whom you need the participant’s medical records for your research. You will send this form to those providers that the participant names to execute the authorization. It is important that the parameters around the request be clearly spelled out – what records do you need, and for what time period?

This form may be used in conjunction with a consent form with a HIPAA Authorization and/or a consent form without a HIPAA Authorization. If you are obtaining informed consent inside a U.S. covered entity, you should use the combined consent/authorization form. If you are obtaining informed consent outside of a covered entity, you may use the consent form without the HIPAA authorization.

* Please complete all the sections indicated.
* Delete this page

**Authorization for Release**

**of Protected Health Information (PHI) for Research**

**Medical Record Release Form**

**Principal Investigator**:

**JHSPH IRB Study No.:**

**Study Title:**

|  |  |
| --- | --- |
| Participant Name: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Date of Birth:  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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|  |  |

We are asking you to authorize the disclosure and use of your private health information (PHI) for this research study.

The people who may receive or use your PHI include the researchers and their staff.

The Health Care Providers listed below are required by the Federal Privacy Rule to protect your private health information. By signing this Authorization, you permit them to release your information to the researchers for use in this research study. The researchers will try to make sure that everyone who needs to see your private information for this research keeps it confidential, but we cannot guarantee this. Although the researchers may not be covered by the Federal Privacy Rule, they will make an effort to protect your information using the same standards.

Some other people may see your PHI outside of the research team. They may include the sponsor of the study, study safety monitors, government regulators, and legal compliance staff. All these people must also keep your information confidential.

You do not have to sign this Authorization, but otherwise you may not join the study. It is your choice.

Your Authorization does not have an expiration date; it will continue as long as the research continues. You may change your mind and take back this Authorization at any time. If you take it back, the researchers may still use the private health information they have collected about you to that point. To take back the Authorization, you must contact the researcher.

I hereby give my consent for:

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 Name of doctor(s) and/or health care provider(s)

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

 Address of doctor(s) and/or health care provider(s)

To provide information from my medical records between:

DATE\_\_\_\_\_\_\_ and DATE\_\_\_\_\_\_\_\_

My health information may be sent to:

**PLEASE INCLUDE STUDY CONTACT INFORMATION HERE**

Participant’s Printed Name Participant’s Signature Date

**If legally authorized representative, sign below and state relationship/authority:**

Legal Representative’s Printed Name Legal Representative’s Signature Date

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

Relationship/Authority

**Note: a copy of the signed authorization must be kept by the principal investigator; a copy must be given to the participant; and if appropriate a copy of the signed authorization must be placed in the participant’s medical record.**