USC HIPAA AUTHORIZATION TO USE HEALTH INFORMATION FOR RESEARCH

1. Purpose of this Form:

A federal law known as the Health Insurance Portability and Accountability Act (HIPAA) protects how your health information is used. HIPAA generally does not allow your health information to be used or released for research purposes without your written permission. Health information protected under the law includes: medical and dental records, bills or other payment records for health care received, tissue samples, x-rays, laboratory results and any other health information that identifies you. State laws also protect how your health information may be used.

By signing this form, you are allowing your health care providers (for example, physicians, dentists, hospitals, clinics) to share your health information with the researchers and others involved in this research study for the uses described below and also described in the informed consent.

2. Who May Release Your Health Information:

This document permits (i) the researcher/health care provider who creates health information about you during this research study; and (ii) the healthcare providers checked below to release health information about you for the research purposes described in this document and the informed consent:

(Check ALL boxes that apply)

- ☑ All health care providers with health information about me
- ☐ Keck Medical Center
- ☐ USC Norris Cancer Hospital
- ☐ Keck Hospital of USC
- ☐ Keck Doctors of USC
- ☐ Children's Hospital Los Angeles
- ☐ LAC+USC Medical Center
- ☐ Herman Ostrow School of Dentistry
- ☐ Other: _____(please specify)

3. What Health Information Will Be Used:

The health care providers listed above are permitted to use and release (i) all health information that is created during this research study; and the health information about you described below:

[CHECK ONE OF THE TWO BOXES BELOW]

☑ All of your health information that the health care provider has in his or her possession, but does not include HIV test results, mental health diagnosis and treatment records, and drug or alcohol treatment records;

OR

☐ Only the following records or types of health information:

_____

(Insert dates of treatment or specific types of treatment, records or reports.)

4. Health Information with Special Protections:

The following information only will be released if you give specific permission by initialing on the line(s) below.

_____ HIV test results.

_____ Mental health diagnosis and treatment records.

_____ Drug and alcohol treatment records.

5. How Your Health Information Will Be Used:

Your health information may be shared with the following individuals or entities for the following purposes:

- Researchers (those individuals in charge of the study), research staff, and students to conduct the research described in the informed consent and other activities related to the research, such as conducting safety analyses.
- The research sponsor(s), NIH/NIDDK [***name of sponsor***], and its authorized representatives, business partners, clinical research organizations and affiliates for the purposes described in the informed consent and for other activities related to the research, such as assessing the safety or efficacy of the

drug, device or treatment included in the study, improving designs of future studies or obtaining approval for new drugs, devices or health care products.

- The USC Institutional Review Boards that review research involving human subjects in accordance with regulations;
- USC's clinical trial organization that supports clinical trials administration at USC,
- Other USC offices involved in regulatory compliance, including the Offices of General Counsel and Compliance,
- U.S. government agencies, such as the Food and Drug Administration and the Office for Human Research Protections, government agencies from other countries, and others who are authorized by law to review or oversee this research.

6. Creation of a Research Database:

The following is an optional research activity. You can choose whether or not to participate in these activities and it will not affect your ability to participate in the main research study. Please initial on the line below to give your specific permission to this activity.

_____ Researchers will often study existing health information from large groups of patients in order to test or validate theories that the researcher develops. By initialing above, you allow the USC research team to put your health information in a research database or repository for future research purposes. The USC Institutional Review Board still may review how the researcher uses or releases your health information for future research purposes.

This section of the Authorization will remain in effect indefinitely unless you revoke (cancel) it as described below.

7. Scope of this Authorization:

The USC research team will use and release your health information for the purposes described in this authorization and the informed consent or as otherwise permitted by

law. However, health information that is shared with others outside USC may not be protected by HIPAA once it is released. Certain health information may still be protected under state law.

8. Right to Deny Access to Health Information:

You may not be permitted to access (review or copy) your health information created during this research study while the research study is in progress. You may be entitled to access your health information once the research study is completed.

9. Term of this Authorization:

Except for database research, this authorization expires 25 years from the date the study is completed or terminated.

10. Refusal to Sign/Right to Revoke:

You must sign this Authorization in order to participate in this research. You may change your mind and revoke (withdraw or cancel) this authorization and your participation in this research study at any time. To do so, your revocation must be sent in writing to the Principal Investigator and include: (1) the title of the research study; and (2) your name and telephone number or address. Please send the revocation to the following:

[Please list the Principal Investigator's name and address below]

Elizabeth Pyatak, PhD, OTR/L, CDE

1540 Alcazar St., CHP-133, Los Angeles, CA 90089-9003 (323) 442 - 2615

You will not be permitted to participate in the research and health information that identifies you will no longer be collected as of the date the Principal Investigator receives your revocation. However, we may still use and share health information about you that has already been obtained as necessary in order to maintain the integrity of the research study. Also, if the law requires it, the researchers, sponsor, and government agencies may continue to look at your records to review the quality or safety of the study.

11. Questions Regarding Your Privacy Rights:

Please contact the USC Office of Compliance by telephone at 213-740-8258 or email at compliance@usc.edu if you have questions about your privacy rights.

Agreement:

I have read (or someone has read to me) the information provided above. I have been given the opportunity to ask questions and all of my questions have been answered to my satisfaction. By signing below, I agree that my health information may be used as described in this form.

Name of Participant	Signature	Date Signed

If Individual is unable to sign this Authorization, please complete the information below:

Name of Legal Guardian/ Personal Representative	Signature	Legal Relationship	Date Signed

You will be given a signed copy of this authorization.