A HIPAA Authorization is your signed permission to allow _________ to disclose your protected health information (PHI) to the researcher(s). If you sign below, you give permission to _________ to disclose (release) your health information that identifies you for the research study titled _________ previously described in the Consent Form. In order to be in this research study you will/do not have to sign this authorization.

The health information that may be used or disclosed (release) for this research includes [complete as appropriate]:

The health information listed above may be used by and/or disclosed (released) to:

___________ is required by law to protect your health information. By signing this document, you authorize _________ to use and/or disclose (release) your health information for this research. Those persons who receive your health information may not be required by Federal privacy laws (such as the Privacy Rule) to protect it and may share your information with others without your permission, if permitted by laws governing them.

However, your information will only be used as described in the above Consent Form for research, unless disclosure is required by law. If all information that does or can identify you is removed from your health information, the remaining information will no longer considered protected health information (PHI) and may be used or disclosed for other purposes. This Authorization expires at the end of the research study.

___________ may not withhold or refuse treating you on whether you sign this Authorization.

Use one of the two following statements:

1. You may change your mind and revoke (take back) this Authorization at any time, except to the extent that _________ has already acted based on this Authorization. To revoke this Authorization, you must write to: <Insert contact information for the Covered Entity and PI>

2. You may change your mind and revoke (take back) this Authorization at any time. Even if you revoke this Authorization, _________ may still use or disclose health information they already have obtained about you as necessary to maintain the integrity or reliability of the current research. To revoke this Authorization, you must write to: <Insert contact information for the Covered Entity and PI>

Use one of the two following statements:

1. If you revoke this Authorization, you will no longer be allowed to participate in the research study previously described in the consent form.

2. If you revoke this Authorization, you will still be allowed to participate in the research study previously described in the consent form.

___________________________________
Signature of participant or legally authorized representative

___________________________________
Date

___________________________________
Printed name of participant or legally authorized representative

If applicable, a description of the legally authorized representative's authority to sign for the participant
HIPAA Revocation
For Participation In Research With NC State

This form is used to revoke or to confirm revocation of a previously authorized disclosure. You may make this revocation at any time by giving written notice. You may only revoke an authorization you made for yourself or your minor child.

Individual Authorizing Use and/or Disclosure of Protected Health Information
Name: __________________________________________________________________________________________
Mailing Address: __________________________________________________________________________________
Phone Number: _____________________________________________________________________________________

Statement of Revocation
I hereby revoke any previous authorizations to disclose my protected health information.

I understand that by signing below, revokes previous authorizations to disclose my protected information.

I understand that no revocation of this consent shall be effective to prevent disclosure of records and/or communications until it is received by the person otherwise authorized to disclose records and communications.

I further understand that the revocation will only apply to further disclosures or actions regarding my personal health information and cannot cancel actions or disclosures made while the disclosure was previously in effect and valid.

Description of Authorization Revoked
Date of Authorization (if known): _____________________________

Protected Health Information: The revoked authorization authorized use and/or disclosure of the following PHI.
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________

___________________________________  ________________________________________
Signature of participant or legally authorized representative  Date

___________________________________  ________________________________________
Printed name of participant or legally authorized representative  If applicable, a description of the legally authorized representative's authority to sign for the participant
Appendix A
Suggestions from NIH, Optional Elements
We encourage using if relevant to the participant that would be signing the waiver

- Your health information may be shared with a public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, and conducting public health surveillance, investigations or interventions.

- No publication or public presentation about the research described above will reveal your identity without another authorization from you.

- When the research for which the use or disclosure is made involves treatment and is conducted by a covered entity: To maintain the integrity of this research study, you generally will not have access to your personal health information related to this research until the study is complete. At the conclusion of the research and at your request, you generally will have access to your health information that [name of the covered entity] maintains in a designated record set, which means a set of data that includes medical information or billing records used in whole or in part by your doctors or other health care providers at [name of the covered entity] to make decisions about individuals. Access to your health information in a designated record set is described in the Notice of Privacy Practices provided to you by [name of covered entity]. If it is necessary for your care, your health information will be provided to you or your physician.
Protected Health Information (PHI): Protected health information is the term given to health data created, received, stored, or transmitted by HIPAA-covered entities and their business associates in relation to the provision of healthcare, healthcare operations and payment for healthcare services. Protected health information is often shortened to PHI, or in the case of electronic health information, ePHI. Protected health information “Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual” that is:

- Transmitted by electronic media;
- Maintained in electronic media; or
- Transmitted or maintained in any other form or medium.

Protected health information includes all individually identifiable health information, including demographic data, medical histories, test results, insurance information, and other information used to identify a patient or provide healthcare services or healthcare coverage. ‘Protected’ means the information is protected under the HIPAA Privacy Rule.

Protected health information is defined in the Code of Federal Regulations and applies to health records, but not education records which are covered by other federal regulations, and neither records held by a HIPAA-covered entity related to its role as an employer. In the case of an employee-patient, protected health information does not include information held on the employee by a covered entity in its role as an employer, only in its role as a healthcare provider.

PHI does not include individually identifiable health information of persons who have been deceased for more than 50 years.

Covered Entity: Under the Privacy Rule, any entity that meets the definition of a covered entity, regardless of size or complexity, generally will be subject in its entirety to the Privacy Rule. Covered entities are defined in the HIPAA rules as

1. health plans
2. health care clearinghouses, and
3. health care providers who electronically transmit any health information in connection with transactions for which HHS has adopted standards.

Generally, these transactions concern billing and payment for services or insurance coverage. Covered entities can be institutions, organizations, or persons.

Researchers are covered entities if they are also health care providers who electronically transmit health information in connection with any transaction for which HHS has adopted a standard. For example, physicians who conduct clinical studies or administer experimental therapeutics to participants during the course of a study must comply with the Privacy Rule if they meet the HIPAA definition of a covered entity.