

**Authorization To Use or Release
Health Information About Me
For Research Purposes**

Authorization B: Enrollment into Research

Study Title: Diabetes Autoimmunity Study in the Young (DAISY)

COMIRB Number: 92-080

I _____ (Patient's Full Name) **authorize**

Marian J Rewers and staff members of DAISY working for him to use the following health information about me **for research**: (Please check the appropriate boxes. NOTE: If a category is checked "yes" and a line follows the category, you MUST describe type and number of the procedures done.)

No Yes

- Name and phone number
- Demographic information (age, sex, ethnicity, address, etc.)
- Diagnosis(es)
- History and Physical
- Laboratory or Tissue Studies: *blood tests on cord blood collected at time of birth*
- Radiology Studies _____
- AIDS or HIV test (or results) _____
- Procedure results _____
- Psychological tests _____
- Survey/Questionnaire: *brief interview conducted at the time of enrollment for genetic screening*
- Research Visit records
- Portions of previous Medical Records that are relevant to this study:
- Billing or financial information _____
- Other (Specify) _____

For the Specific Purpose of

- Collecting data for this research project
- Other* _____

*Cannot say "for any and all research", "for any purpose", etc.

The research team may also need to disclose this information to others as part of the study process. The others may include federal agencies overseeing human subject research, the Colorado Multiple Institutional Review Board, regulatory officials from the institution where the research is being conducted to monitor safety and compliance with policies and the data and safety monitoring board of the study (when applicable).

If my health information that identifies me is also going to be given out to others outside the facility, the recipients are described on the next page(s).

- No personally identifiable health information about me will be disclosed to others**

The PI (or staff acting on behalf of the PI) will also make the following health information about me available to: (check all that apply and **describe type and number of the procedures** done where applicable)

NONE

No Yes

- All Research Data Collected in this Study
- Name and phone number
- Demographic information (age, sex, ethnicity, address, etc.)
- Diagnosis(es)
- History and Physical
- Laboratory or Tissue Studies _____
- Radiology Studies _____
- AIDS or HIV test (or results) _____
- Psychological tests _____
- Survey _____
- Research Visit records
- Portions of previous Medical Records that are relevant to this study
- Billing/Charges
- Other (Specify) _____

For the Specific Purpose of

- Evaluation of this research project
- Evaluation of laboratory/tissue samples
- Data management
- Data analysis

Other* _____

**Cannot say "for any and all research", "for any purpose", etc.*

Recipient NONE

No Yes

- All Research Data Collected in this Study
- Name and phone number
- Demographic information (age, sex, ethnicity, address, etc.)
- Diagnosis(es)
- History and Physical
- Laboratory or Tissue Studies _____ results of cord blood screening for HLA markers
- Radiology Studies _____
- AIDS or HIV test (or results) _____
- Psychological tests _____
- Survey _____
- Research Visit records
- Portions of previous Medical Records that are relevant to this study
- Billing/Charges
- Other (Specify) _____

For the Specific Purpose of

- Evaluation of this research project
- Evaluation of laboratory/tissue samples
- Data management
- Data analysis

Other* _____

**Cannot say "for any and all research", "for any purpose", etc.*

For additional Recipients, copy this page as needed.

I give my authorization knowing that:

- I do not have to sign this authorization. But if I do not sign it the researcher has the right to not let me be in the research study.
- I can cancel this authorization any time.
 - I have to cancel it in writing.
 - If I cancel it, the researchers and the people the information was given to will still be able to use it because I had given them my permission, but they won't get any more information about me.
 - If I cancel my authorization, I may no longer be able to be in the study.
 - I can read the Notice of Privacy Practices at the facility where the research is being conducted to find out how to cancel my authorization.
- The records given out to other people may be given out by them and might no longer be protected.
- I will be given a copy of this form after I have signed and dated it.

This authorization will expire on: _____ (Date) OR

- The end of the research study
 Will not expire

ADDITIONAL INFORMATION: _____

Patient's Signature

Date

Signature of Legal Representative (If applicable)

Date

Name of Legal Representative (please print)

Description of Legal Authority to Act on Behalf of Patient