Exempla Healthcare
Authorization

TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

TITLE: Diabetes Autoimmunity in the Young (DAISY) (COMIRB Protocol 92-080)

We are required to obtain your authorization to use and/or disclose your protected health information for this research study.

The U.S. Government has issued a new rule that took effect on April 14, 2003 called the Privacy Rule. This rule requires Exempla Healthcare to protect the privacy of your health information. The health information that we are to protect includes information about you that could be used to link your identity to your health information. Before researchers can use and/or disclose your protected health information (PHI) in the research study, your authorization must be obtained.

Description of the information to be used

Your Protected health information includes information contained in your medical record or in the Exempla Healthcare computer information system. The PHI to be used in for this study includes:

No Yes

- ☒ ☐ Clinicans' (doctors and other caregivers) notes and reports
- ☒ ☐ Test results such as laboratory reports, x-ray results, special studies
- ☒ ☐ Medication records
- ☒ ☐ Reports of Procedures or operations
- ☐ ☒ Other, Specify: Name and phone number, Demographic information (age, ethnicity, address,etc.)
- ☒ ☐ Specific encounter date:_____
- ☒ ☐ All Previous encounters
- ☒ ☐ Information that may include or reference to the following condition (s): behavioral health services/psychiatric care; sickle cell anemia; genetic testing; acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV); or drug and/or alcohol abuse.

Information to be used and/or disclosed from

- ☐ Lutheran Medical center
- ☒ Saint Joseph Hospital
- ☐ West Pines
- ☐ Colorado Lutheran Home
- ☐ Physician Network (Specify Site):_____

Information to be used and/or disclosed to

- Dr. Marian Rewers (Principal Investigator) and staff members of the study
- Barbara Davis Center for Childhood Diabetes
- The Exempla St. Joseph Hospital research team may also disclose your health information to others outside Exempla St. Joseph Hospital. Your Health information may be viewed by the following people to monitor this study as required by law:
  - Dept. Of Health and Human Services agencies
  - Colorado Multiple Institutional Review Board

- National Institute of Health (NIH)
- Exempla Healthcare Institutional Review Board

Purpose of the use and/or disclosure of your PHI

Exempla Healthcare researchers will use your health information to conduct the study.

Expiration date of this authorization

This authorization expires at the end of the research study

Right to Revoke this Authorization

This Authorization may be revoked in writing at any time except to the extent that PHI has been used and/or disclosed prior to the revocation. If you withdraw your authorization, you may be required to end your participation in the study. Even if you withdraw your authorization, the researchers are required by federal law to record and report anything that relates to your safety and the safety of others.

Conditions of this authorization

- To participate in this research study, you must agree to authorize the use and/or disclosure of your PHI as described above. If you do not approve this use and/or disclosure, you cannot participate in this study
- The Exempla Healthcare research team will use and/or disclose your PHI only as permitted by you in this authorization. Once your health information has been disclosed outside of Exempla Healthcare, it will no longer be protected by the HIPPA Privacy Rule; although, it will be treated as confidential, consistent with federal regulations.

Signature and Date

My signature is required to validate this authorization. If I do not sign this authorization, Exempla Healthcare will still provide treatment and seek payment for services provided; however I will not be able to participate in the research study.

Parents sign here please

_____ _____

Signature of Personal Representative if participant Cannot give authorization **Date**

_____ _____

Signature of Participant Date

_____

Personal Representative's authority
(e.g., Power of Attorney, Guardian, Personal Representative)

Provide a copy of the signed authorization to the patient