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 _____ *(Subject's Full Name)* **authorize**

Marian Rewers *(PI or Physician Name)* **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/or phone number
☐ ☒ Demographic information (age, sex, ethnicity, address, etc.)
☐ ☒ Diagnosis(es)
☐ ☒ History and/or Physical
☐ ☒ Laboratory or Tissue Studies: *laboratory tests on blood, urine, saliva, stool, collected at research visits*
☒ ☐ Radiology Studies _____
☒ ☐ Testing for or Infection with Human Immunodeficiency Virus (HIV) (or results) **
☒ ☐ Procedure results _____
☒ ☐ Psychological tests _____
☐ ☒ Survey/Questionnaire: *as described in the consent and collected by mail, phone and at each research visit*
☐ ☒ Research Visit records
☐ ☒ Portions of previous Medical Records that are relevant to this study: *immunization records*
☒ ☐ Billing or financial information
☒ ☐ Drug Abuse **
☒ ☐ Alcoholism or Alcohol abuse **
☒ ☐ Sickle Cell Anemia **
☐ ☐ Other (Specify) _____

** ***when this category of information is included for VA patients, an authorization expiration date or condition is required on page 3***

For the Specific Purpose of

☒ Collecting data for this research project
☐ Other* _____

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

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)

Recipient The Children's Hospital Denver

No Yes

☒ ☐ All Research Data Collected in this Study (if you check this box Yes, no other boxes need to be checked in this section)

☐ ☒ Name and phone number
☐ ☒ Demographic information (age, sex, ethnicity, address, etc.)
☐ ☒ Diagnosis(es)
☐ ☒ History and Physical
☐ ☒ Laboratory or Tissue Studies: *laboratory tests on blood, urine, saliva, stool, collected at research visits*
☒ ☐ Radiology Studies _____
☒ ☐ Testing for or Infection with Human Immunodeficiency Virus (HIV) (or results) **
☒ ☐ Procedure results _____
☒ ☐ Psychological tests _____
☐ ☒ Questionnaire/Survey: *as described in the consent and collected by mail, phone and at each research visit*
☐ ☒ Research Visit records
☐ ☒ Portions of previous Medical Records that are relevant to this study: *immunization records*
☒ ☐ Billing/Charges
☒ ☐ Drug Abuse **
☒ ☐ Alcoholism or Alcohol **
☒ ☐ Sickle Cell Anemia **
☐ ☐ Other (Specify) _____

***when this category of information is included for VA patients, an authorization expiration date or condition is required on page 3*

For the Specific Purpose of

☐ Evaluation of this research project
☐ Evaluation of laboratory/tissue samples
☒ Data management
☒ Data analysis
Other* As support for clinical care

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

For additional Recipients, copy this page as needed.

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)

Recipient Barbara Davis Center

No Yes

☒ ☐ All Research Data Collected in this Study (if you check this box Yes, no other boxes need to be checked in this section)

☐ ☒ Name and phone number
☐ ☒ Demographic information (age, sex, ethnicity, address, etc.)
☐ ☒ Diagnosis(es)
☐ ☒ History and Physical
☐ ☒ Laboratory or Tissue Studies: *laboratory tests on blood, urine, saliva, stool, collected at research visits*
☒ ☐ Radiology Studies _____
☒ ☐ Testing for or Infection with Human Immunodeficiency Virus (HIV) (or results) **
☒ ☐ Procedure results _____
☒ ☐ Psychological tests _____
☐ ☒ Questionnaire/Survey: *as described in the consent and collected by mail, phone and at each research visit*
☐ ☒ Research Visit records
☐ ☒ Portions of previous Medical Records that are relevant to this study: *immunization records*
☒ ☐ Billing/Charges
☒ ☐ Drug Abuse **
☒ ☐ Alcoholism or Alcohol **
☒ ☐ Sickle Cell Anemia **
☐ ☐ Other (Specify) _____

***when this category of information is included for VA patients, an authorization expiration date or condition is required on page 3*

For the Specific Purpose of

☐ Evaluation of this research project
☐ Evaluation of laboratory/tissue samples
☒ Data management
☒ Data analysis
Other* As support for clinical care

**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

☐ _____

(Describe dates or circumstances under which the authorization will expire. This is required for VA patients, when using or disclosing information on AIDS/HIV testing or results, sickle cell anemia, and treatment for drug or alcohol abuse, and alcoholism.)

ADDITIONAL INFORMATION: _____

_____

_____

_____

Subject'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