Authorization To Use or Release Health Information About Me For Research Purposes *Authorization B: Enrollment into Research*	Study Title: The Diabetes Autoimmunity Study in the Young (DAISY) COMIRB Number: 92-080

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

_____**and staff members of** _____

working for him/her to use the following health information about me <u>for research</u>:

No Yes
☐ ☒ 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) _____
☒ ☐ Procedure results _____
☒ ☐ Psychological tests _____
☒ ☐ Survey/Questionnaire _____
☒ ☐ Research Visit records
☐ ☒ Portions of previous Medical Records that are relevant to this study: ***Immunization Records***
☒ ☐ 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)

Recipient Marian Rewers, MD, PhD and staff members of DAISY working for him

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: ***Immunization Records***
☒ ☐ 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.*

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