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| **Institutional Review Board (IRB)** |  | **IRB Form 6.2**  HIPPA Privacy Authorization  Agreement |

**Note:** This form is used to authorize the use or disclosure (release) of health-related information that identifies you in a research study. In accordance with the HIPPA Privacy Rule, this document needs to be filled out in addition to a (potential) informed consent form (though the two may be combined).

Dear Participant,

If you sign this document, you give permission to the University of North Georgia (UNG) to use or disclose (release) your health information that identifies you for the research study described here:

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| **Title of Research Project:** |  |
| **Purpose of Research:** | |

The health information UNG may use or disclose (release) for this research study includes information in your medical record, results of physical exams, medical history, lab tests or certain health information indicating or relating to your condition.

The health information listed above may be used by and/or disclosed (released) to the following, as applicable:

* the sponsor of the study including its agents such as data repositories or contract research organizations monitoring the study;
* other institutions and investigators participating in the study;
* data safety monitoring boards;
* accrediting agencies;
* clinical staff not involved in the study whom may become involved if it is relevant;
* health insurer or payer in order to secure payment for covered treatment;
* parents of minor children <16 years old; parents of children 16 years old or older require authorization from the child; or
* federal and state agencies and MUSC committees having authority over the study such as:
* the Institutional Review Board (IRB) overseeing this study;
* committees with quality improvement responsibilities;
* Office of Human Research Protections (OHRP);
* Food and Drug Administration (FDA);
* National Institutes of Health (NIH); or
* other governmental offices, such as a public health agency or as required by law.

UNG is required by law to protect your health information. By signing this document, you authorize UNG 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.

You do not have to sign this authorization. If you choose not to sign, it will not affect your treatment, payment or enrollment in any health plan or affect your eligibility for benefits. However, you will not be allowed to be a participant in this research study.

You may change your mind and revoke (take back) this authorization at any time. Even if you revoke this authorization, UNG may still use or disclose (release) health information already obtained about you as necessary to maintain the integrity or reliability of the research study. If you revoke this authorization, you may no longer be allowed to participate in this research study. To revoke this authorization, you must write to:

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|  | **Principal Investigator’s Name:** |  |
|  | **Full Address:** |  |
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|  | **Email Address:** |  |

You will not be allowed to see or copy the information described on this authorization as long as the research study is in progress. When the study is complete, you have a right to see and obtain a copy of the information.

Your health information will be used or disclosed when required by law. 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 for conducting public health surveillance, investigations or interventions. No publication or public presentation about the research study will reveal your identity without another signed authorization from you.

You will be given a copy of this authorization. This authorization will expire at the end of the research study. If you have questions or concerns about this authorization or your privacy rights, please contact UNG’s IRB Chair at \_\_\_\_\_\_\_ *(need phone number here)*.

Regulations require that you be given a copy of the UNG Notice of Privacy Practices (NPP) describing the practices of UNG regarding your health information. One can be found at the end of this form.

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|  | Signature of Research Participant ages 16 & above\* |  | Date |
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|  | Research Participant’s Legally Authorized Representative |  | Date |
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|  | Printed Name of Participant (or legally authorized representative, if applicable) | | |

\*If the research participant is 16 to 18 years of age, signatures of both the research participant and the Legally Authorized Representative are required.

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|  | NOTICE OF PRIVACY PRACTICES |
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**Note: This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

Here is a list how we use and/or release your protected health information (PHI).

**A. The following uses do not require your authorization (except where defined by GA law)**

1. For treatment. Your PHI may be discussed by caregivers to determine your plan of care. For example, the physicians, nurses, medical students and other health care personnel may share PHI in order to coordinate the services you may need.
2. To obtain payment. We may use and disclose PHI to obtain payment for our services from you, an insurance company or a third party. For example, we may use the information to send a claim to your insurance company.
3. For health care operations. We may use and disclose PHI for hospital and/or clinic operations. For example, we may use the information to review our treatment and services and to evaluate the performance of our staff in caring for you.
4. For public health activities. We report to public health authorities, as required by law, information regarding births, deaths, various diseases, reactions to medications and medical products.
5. Victims of abuse, neglect, domestic violence. Your PHI may be released, as required by law, to the South Carolina Department of Social Services when cases of abuse and neglect are suspected.
6. Health oversight activities. We will release information for federal or state audits, civil, administrative or criminal investigations, inspections, licensure or disciplinary actions, as required by law.
7. Judicial and administrative proceedings. Your PHI may be released in response to a subpoena or court order.
8. Law enforcement or national security purposes. Your PHI may be released as part of an investigation by law enforcement.
9. Uses and disclosures about patients who have died. We provide coroners, medical examiners and funeral directors necessary information related to an individual’s death.
10. For purposes of organ donation. As required by law, we will notify organ procurement organizations to assist them in organ, eye or tissue donation and transplants.
11. Research. We may use your PHI if the Institutional Review Board (IRB) for research reviews, approves and establishes safeguards to ensure privacy.
12. To avoid harm. In order to avoid a serious threat to the health or safety of a person or the public, we may release limited information to law enforcement personnel or persons able to prevent or lessen such harm.
13. For workers compensation purposes. We may release your PHI to comply with workers compensation laws.
14. Marketing. We may send you information on the latest treatment, support groups and other resources affecting your health.
15. Fundraising activities. We may use your PHI to communicate with you to raise funds to support health care services and educational programs we provide to the community. You have the right to opt out of receiving fundraising communications with each solicitation.
16. Appointment reminders and health-related benefits and services. We may contact you with a reminder that you have an appointment.

**B. You may object to the following uses of PHI**

1. Hospital directories. Unless you object, we may include your name, location, general condition or religious affiliation in our patient directory for use by clergy/visitors who ask for you by name.
2. Information shared with family, friends or others. Unless you object, we may release your PHI to a family member, friend, or other person involved with your care or the payment for your care.
3. Health plan. You have the right to request that we not disclose certain PHI to your health plan for health services or items when you pay for those services or items in full.

**C. Your prior written authorization is required to release PHI in the following situations:**

1. Any uses or disclosures beyond treatment, payment or healthcare operations and not specified in parts A & B above.
2. Psychotherapy notes.
3. Any circumstance where we seek to sell your information.

**Note:** You may revoke your authorization by submitting a written notice to the privacy contact identified

below. If we have a written authorization to release your PHI, it may occur before we receive your revocation.

**WHAT RIGHTS YOU HAVE REGARDING YOUR PHI**

Although your health record is the physical property of the healthcare facility, the information belongs to you, and you have the following rights with respect to your PHI:

1. The right to request limits on how we use and release your PHI. You have the right to ask that we limit how we use and release your PHI. We will consider your request, but we are not always legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. Your request must be in writing and state (a) the information you want to limit; (b) whether you want to limit our use, disclosure or both; (c) to whom you want the limits to apply, for example, disclosures to your spouse; and (d) an expiration date.
2. The right to choose how we communicate PHI with You. You have the right to request that we communicate with you about PHI in a certain way or at a certain location (for example, sending information to your work address rather than your home address). You must make your request in writing and specify how and where you wish to be contacted. We will accommodate reasonable requests.
3. The right to see and get copies of Your PHI. You have the right to inspect and receive a copy of your PHI (including an electronic copy), which is contained in a designated record set that may be used to make decisions about your care. You must submit your request in writing. If you request a copy of this information, we may charge a fee for copying, mailing or other costs associated with your request. We may deny your request to inspect and receive a copy in certain very limited circumstances. If you are denied access to PHI, you may request that the denial be reviewed.
4. The right to get a list of instances of when and to whom we have disclosed your PHI. This list may not include uses such as those made for treatment, payment, or health care operations, directly to you, to your family, or in our facility directory as described above in this Notice of Privacy Practices. This list also may not include uses for which a signed authorization has been received or disclosures made more than six years prior to the date of your request.
5. The right to amend your PHI. If you believe there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we amend the existing information or add the missing information. You must provide the request and your reason for the request in writing. We may deny your request in writing if the PHI is correct and complete or if it originated in another facility’s record.
6. The Right to Receive a Paper or Electronic Copy of This Notice: You may ask us to give you a copy of this Notice at any time. For the above requests (and to receive forms) please contact:

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|  | **Principal Investigator Name:** |  |
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|  | **Phone Number:** |  |
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|  | **Address:** |  |
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1. The right to revoke an authorization. If you choose to sign an authorization to release your PHI, you can later revoke that authorization in writing. This revocation will stop any future release of your health information except as allowed or required by law.
2. The right to be notified of a breach. If there is a breach of your unsecured PHI, we will notify you of the breach in writing.

**HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES**

If you think your privacy rights may have been violated, or you disagree with a decision we made about access to your PHI, you may file a complaint with the office listed in the next section of this notice. Please be assured that you will not be penalized and there will be no retaliation for voicing a concern or filing a complaint.

**PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES**

If you have any questions about this Notice or any complaints about our privacy practices please call the UNG IRB Chair at \_\_\_\_\_\_ (need phone number here), or contact in writing: IRB Chair, University of North Georgia, \_\_\_\_\_\_\_\_ (need remainder of address). You also may send a written complaint to the Office of Civil Rights. The address will be provided at your request.

**CHANGES TO THIS NOTCE**

We reserve the right to change the terms of this Notice at any time. We also reserve the right to make the revised or changed Notice effective for existing as well as future PHI. This Notice will always contain the effective date.

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| **EFFECTIVE DATE OF THIS NOTICE:** |  |
|  | *enter effective date above* |