Individual Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

|  |  |
| --- | --- |
| **Title of Study** |  |
| **Protocol # (if applicable)** |  |
| **Study Subject Name** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Please read this form before you sign it.**

**If you don’t know what something means, you can ask us.**

**Before you sign this, you can talk it over with someone you trust.**

In our research, we use and share information about people and their health. We know that this information is private. Federal law protects health information.

The law lets FSU staff use and share information as a part of doing business. This means FSU may use and share information about you:

* To treat you or provide information regarding your health.
* To do billing and get payment.
* To make sure our work is of high quality.

The law lets us use and share health information for research if you agree to let us do this. If you let us use and share information about you, we will protect it as required by law.

If you sign this form, it means you are letting us use and share this information for research.

**Who will disclose (share), receive, and/or use your information?**To do this research, FSU and the people and organizations listed below may use or share your information. They may only use and share your information:

* With the people and organizations on this list.
* With you or your personal representative.
* As allowed by law.

FSU and the people and organizations listed below may use or share information about you to do this research:
The Mind Research Network for MRI radiology review purposes; Derek Nee, FSU MRI Facility Scientific Director; Colm G. Connolly, FSU MRIF Associate Director; Alecia Lapointe, FSU MRI Facility Technologist and Program Director; The PI of this study and their research team.

1) Authorization:

 I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize the MRI facility at Florida State University, at the College of Medicine (the Facility) to collect, use and disclose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(’s) protected health information (PHI) to Mind Research Network for MRI radiology review purposes, Greg Hajcak, Colm G. Connolly, Alecia Lapointe, the PI of this study and their research team at the request of the individual for the purposes of research.

*This information will be limited to the generated image data of (name of research participant) from the MRI scan and the contact information for release to the referring researcher or their staff for use in an IRB approved research project*.

2) Effective Period: This authorization for release of PHI is in full effect until the conclusion of research.

3) Extent of Authorization: By signing below, I authorize the release of any PHI provided by me and/or generated by the Facility.

4) I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

5) I understand that PHI used or disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal law.

6) I understand that I do not have to sign this Authorization, but if I do not, I will not receive authorization to participate as a research subject.

Signature of participant or participant’s personal representative

Printed name of participant or participant’s personal representative Date