MAYFIELD
CLINIC
506 Oak Street, Cincinnati, OH 45219
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PATIENT AUTHORIZATION FOR RESEARCH

Authorization to Use and Disclose Health Information for Research Purposes

Under federal law, researchers who use information about the health of their research participants are required, except in specific circumstances, to get written permission to use their participants' health information for the research study. Because you have agreed to participate in a research study or research activity, your written permission is needed to allow the use and disclosure of your health information. Your health information that will be used and disclosed for this Research Study or research activity includes your existing medical records and information created or collected during the Research Study or activity. In order to take part in this Research, you must sign this Authorization.

What is the Purpose of this Authorization?

The purpose of this Authorization is to allow the people and/or groups listed below to use and/or disclose certain information about your health for the Research study or research activity entitled:

Study / Article Title ____

____

Principal Investigator / Author ____

at ❑ Mayfield Clinic ❑ University of Cincinnati, Department of Neurosurgery ❑ Other ____________________

What Information Will Be Used and/or Disclosed For the Research Study or Research Activity?

The following information about your health will be used and/or disclosed for the Research entitled above:

- ❑ Any portion of your medical chart, both inpatient medical record, consultation record or outpatient clinic chart
- ❑ Any pictures, slides, films, or electronic record
- ❑ Demographic information
- ❑ Billing information
- ❑ Other to include:________________________________

Who Will Disclose My Health Information for this Research Study?

By signing this authorization, you permit your doctors and other heathcare providers listed below to release health information about you to the Principal Investigator(s) and their research staff for the purposes of this Research Study or Research Activity:

- ❑ Principal Investigator ____
- ❑ Any Member of the Research Study Team including the co-investigators, study coordinator
- ❑ Mayfield Clinic Workforce (administrative staff, medical communication staff, physicians, nurses, residents and fellows
- ❑ Any consulting medical personnel
- ❑ Office of Clinical Trials at the University of Cincinnati
- ❑ Institutional Review Board at ____
- ❑ Other ____

How Will My Health Information be Used and Disclosed for this Research Study or research activity?

The Principal Investigator(s) and their research team will use your health information for this Research. In addition, your health information may be disclosed to others for their use with regards to this Research Study or Research Activity including Sponsor(s) of this Research Study and its representatives and business partners Federal & State Agencies that Regulate Research including:

- ❑ the FDA
- ❑ University of Cincinnati
- ❑ Contract Research Organization ____
- ❑ Site Management Organization ____
- ❑ Other Sites for this Research Study including ____
- ❑ National Institutes of Health
- ❑ Data Safety Monitoring Board
- ❑ Institutional Review Board, at ____
- ❑ National Cancer Institute
- ❑ Office for Human Research Protections
- ❑ Study Sponsor ____
- ❑ Data Management Center ____
- ❑ Publication in a journal, book or abstract ____
- ❑ Others, (Include agencies in other countries) ____

How Long Will My Permission Last?
This Authorization does not have an automatic end date. However, you have the right to end this Authorization by withdrawing it, in writing, at any time. Please note if you revoke this Authorization, researchers may continue to use or disclose your health information *ALREADY* collected as is necessary to protect the overall integrity of this Research Study. If you withdraw this Authorization, you can no longer actively participate in the Research Study.

Your withdrawal must be made in writing and addressed to:

Mayfield Clinic
c/o The Director of Clinical Trials
University of Cincinnati
Department of Neurosurgery
231 Albert Sabin Way ML # 0515
Cincinnati, Ohio 45267-0515

Is My Permission Voluntary?
You are not required to sign this form, and you may refuse to do so. If you decide not to sign this Authorization, it will not affect your healthcare, payment or enrollment in any health plans or affect your eligibility for benefits. However, if you refuse to sign this form, you cannot participate in the Research and you cannot obtain any of the research-related treatment, because the researchers will not be able to access the information they need to conduct their research.

Could My Health Information Be Disclosed Outside the Research Study?
Once health information has been disclosed outside of this study, the health information may no longer be subject to federal health privacy laws and they may be permitted to re-disclose your health information without your prior permission. For example, if you are participating in a study to test the effectiveness of a new drug, your health information may be disclosed to a pharmaceutical company that is sponsoring the research, and that company may not be subject to federal health privacy laws. Please refer to your Research Subject and Information Consent Form, if required, for additional information regarding confidentiality protections outside the Research Study.

Will I Be Allowed to See My Research Records?
During the course of the Research Study, you will not have the right to inspect or copy your medical information which has been obtained or created by the researchers. When the Research Study has been completed, you will have the right to inspect or copy these records, with certain exceptions provided under applicable law and Mayfield Clinic's access policy. If, after the completion of the Research Study, you would like to inspect or copy your records, please submit your request in writing to:

Mayfield Clinic
c/o The Director of Clinical Trials
University of Cincinnati
Department of Neurosurgery
231 Albert Sabin Way ML # 0515
Cincinnati, Ohio 45267-0515

Certification and Signatures.
You should take as much time as you need to decide whether you wish to permit the use and disclosure of your health information for the Research Study. Please feel free to ask questions about any aspects of this Authorization that are unclear to you.

Subject Certification: I, have read this Authorization, which describes how my health information will be used and/or disclosed for the Research Study. I have had the opportunity to ask, and I have received answers to, any questions I had regarding the use and disclosure of my health information for the Research Study. I agree to the use and/or disclosure of my health information, as described above, for the Research Study.

Signature of Subject ______________________________ Date ____/____/____

Signature of Legally Authorized Representative (if any): ______________________________

Source of Authority to act for Subject (relationship to subject): ______________________________

Signature of Investigator or Person Obtaining Authorization: ______________________________ Date: ____/____/____

YOU SHOULD RECEIVE A COPY OF THIS FORM AFTER SIGNING IT.

This form has been approved by the Mayfield Clinic March, 2003.