<<REMOVE ALL INSTRUCTIONS IN RED BEFORE PRINTING. PRINT ON RADFORD UNIVERSITY LETTERHEAD >>

**AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION FOR RESEARCH**

Principal Investigator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title of the Study: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This form relates to the above study. It tells you what information about you may be collected in this study and who might see or use it. You have also been given a consent form that tells you about the study and any activities or procedures that are part of the study.

Radford University has rules to protect information about you. Federal and state laws also protect your privacy.

Generally, only people on the research team will know that you are in the research study and will see your information. However, there are a few exceptions such as the ones that are listed later in this form.

The people working on the study will collect information about you. This includes things learned from the procedures described in the study consent form. They may collect other information including your name, address, date of birth, and other details.

**<< Include the following provision(s) if applicable; otherwise delete the following provision in its entirety >>**

As a part of this study, the researchers may ask to see your health care records from your other health care providers.

**<< Researcher: Select only one of the following two alternatives. >>**

We will ask these other health care providers to give us ANY information about your health status or your health care.

**<< OR >>**

We will ask these other health care providers to give us information about your health status or your health care involving **<< Researcher: specify any particular type of health information that is appropriate >>**

**<< Optional: >>** You will be asked to give us a list of other health care providers that you use.

The research team will need to see your information. Sometimes other people at Radford University may see or give out your information. These people include people who review the research studies, their staff, lawyers, or other Radford University staff.

People outside of Radford University may need to see your information for this study. Examples include government groups (such as the Food and Drug Administration), safety monitors, other universities and medical centers involved in the study and sponsors of the study.

We cannot do this study without your permission to use and give out your information. You do not have to give us this permission. If you do not, then you may not join this study.

We will use and disclose your information only as described in this form; however, people outside Radford University who receive your information may not be covered by this promise. We try to make sure that everyone who needs to see your information uses it only for the study and keeps it confidential – but we cannot guarantee this.

The use of your information has no time limit. You can cancel your permission to use and disclose your information at any time by calling the Radford University IRB at (540) 831-5290 or by sending a letter to:

 Radford University Institutional Review Board

 P.O.  Box 6926

 Radford, VA 24142

Your cancellation would not affect information already collected in this study.

Printed Name and Signature of Participant Date

Printed Name and Signature of Person Obtaining Consent Date

**[Add any of the following that are applicable for this study and delete any that do not apply]**

Name and Signature of Legally Authorized Representative Date

Relationship of Legally Authorized Representative:

This is for **ADULTS NOT** **CAPABLE of GIVING CONSENT** (Persons from the following categories in order of priority may be a Legally Authorized Representative

*“Legally authorized representative"* means, in the following specified order of priority, (i) the parent or parents having custody of a prospective subject who is a minor, (ii) the agent appointed under an advance directive, provided the advance directive authorizes the agent to make decisions regarding the prospective subject's participation in human research, (iii) the legal guardian of a prospective subject, (iv) the spouse of the prospective subject, except where a suit for divorce has been filed and the divorce decree is not yet final, (v) an adult child of the prospective subject, (vi) a parent of the prospective subject when the subject is an adult, (vii) an adult brother or sister of the prospective subject or (viii) any person or judicial or other body authorized by law or regulation to consent on behalf of a prospective subject to such subject's participation in the particular human research.

Printed Name and Signature of Parent/Guardian Date

Printed Name and Signature of Parent #2 (if 45 CFR 406 or 407 study) Date

Printed Name and Signature of Child Participant Date

Printed Name and Signature of Witness to Consent Procedures Date

**NOTE**: **A COPY OF THE SIGNED CONSENT FORM MUST BE KEPT BY THE PRINCIPAL INVESTIGATOR; A COPY MUST BE GIVEN TO THE PARTICIPANT; AND, IF APPROPRIATE A COPY OF THE SIGNED CONSENT MUST BE PLACED IN THE PARTICIPANT’S MEDICAL RECORD.**