**MONTEFIORE MEDICAL CENTER** | **ALBERT EINSTEIN COLLEGE OF MEDICINE OF YESHIVA UNIVERSITY**

# AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION FOR A RESEARCH STUDY

You have agreed to participate in the research study titled: The EpiNet Project: An International Pilot Study

AECOM CCI #: _____ MMC IRB#: 10-04-109E

Principal Investigator Name: Alexis D. Boro, MD

You authorize use or disclosure of the information described below.

ACKNOWLEDGEMENT
JUL 31 2010
INSTITUTIONAL REVIEW BOARD

**The information may be disclosed, as applicable, by:**

- The research team (investigators, nurses, data managers, etc.)
- Montefiore Medical Center
- Albert Einstein College of Medicine (Yeshiva University)

**The information may be disclosed, as applicable, to:**

- Montefiore Medical Center
- Albert Einstein College of Medicine (Yeshiva University)
- The sponsor(s) of this research, other centers involved in this research and any company with which the sponsor has contracted to oversee the research
- U.S. Food and Drug Administration, the U.S. Office of Human Research Protection, other federal agencies involved with research

**The following information is to be disclosed:**
The specific health information about you to be used or disclosed in the research includes all personally identifiable health information concerning you collected or generated as a result of this research. The purpose of the use and/or disclosure of Protected Health Information is to be able to use the information collected about you in the results of the research.

**Right to Revoke:** You have the right to revoke (or cancel) this authorization at any time. If you revoke this authorization, you must do so in writing. The revocation will not apply to information that has already been disclosed based on this authorization.

**Expiration:** This Authorization does not have an automatic end date.

**Redisclosure:** Your information may be re-disclosed by the organization that receives it, and the information may no longer be protected by HIPAA rules. Please refer to the Confidentiality Section of your Research Subject and Information Consent Form for additional information regarding confidentiality outside the Research Study.

**Other Rights:** Authorizing the disclosure of this health information is voluntary. You can refuse to sign this authorization. You do not need to sign this form to assure treatment. However, since this authorization is needed for participation in a research study, your enrollment in the research study may be denied.

During the course of the Research Study, you will not have the right to see or copy your Protected Health Information that is used in the Research Study. 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. If, after the completion of the Research Study, you would like to see or copy your records, please contact Dr. Alexis Boro, MD at (718) 920-4898 for further information.

| **Signature of Research Participant/Authorized Representative** | **Date** | **Printed Name of Individual Signing Form** |
|---|---|---|
| **Printed Name of Research Participant (If different from the individual signing the form.)** | | **Relationship of Individual Signing Form** |