Appendix J: Sample Authorization Form B

Revised Date: 12/01/20

Authorization to Release Health Information About Me for Research Purposes

I _____ (Patient's Full Name) authorize _____ (Principal Investigator or Physician Name) and staff members of _____ (Facility Name) working for him/her to use or give the following health information about me for the purpose of research recruitment:

☐ Name, Address, and/or telephone number

☐ Other (Specify) (e.g., laboratory or test results)

This information will be given to: _____

I give my authorization knowing that:

- I do not have to sign this authorization. If I do not sign it, my information will not be released for research recruitment.
- I can cancel this authorization any time.
- I have to cancel it in writing.
- If I cancel it, the researchers and the people my information was given to may have already used the information, but they will not use it in the future.
- I can read the Notice of Privacy Practices at the facility where the research is being conducted to find out how to cancel my authorization.
- The records given out to other people may be given out by them and might no longer be protected.
- I will be given a copy of this form after I have signed it.

This authorization (check one):

☐ will not expire OR ☐ will expire on: _____ (mm/dd/yyyy)

Additional information: _____

Patient's Signature: _____ Date: _____