#### **PROTECTED HEALTH INFORMATION AUTHORIZATION FORM**

Researchers from the study “     ” would like **your permission** to **use your** **health information** which will be gathered as a part of this study.

The following **health information** will be **gathered** from you:

The **names of the TCU researchers** who will gather this information from you are (insert the names of all TCU researchers starting with the lead researcher):

Your **health information** **may be shared** with others who are working with the TCU researchers on this study, institutes that are paying for this study or involved in any other way, or as required by law. The names of these other researchers (include name, affiliation, and role in the study) or institutions (name and role in the study) are listed below.

The TCU researchers and other researchers who work with TCU will **protect** your **health information** in the following ways:

* Your health information will be kept **private**
* Your **name or any other identifying information will not** be madeknown
* Your health information may be shown in research papers or meetings **without any information about you** that will link it to you.
* Your health information will be given a **special code** for security
* Your health information will be **grouped together with other people’s** health information to form an average
* Your health information will be **locked in a cabinet** and kept safe

You can agree or not agree to sign this form. If you agree to sign this form but change your mind, you can **choose to stop** being in the study at any time. If you decide to stop being in the study, you will need to contact the researcher (insert the name, telephone, and e-mail of the PI):

You will be **given a copy** of this form to keep.

If you have any **questions or concerns** about **your rights** as a study participant, you can contact:

Dr. Cathleen Cox, Chair, TCU Institutional Review Board, Phone 817-257-6418.

Dr. Bonnie Melhart, TCU Research Integrity Office, Telephone 817-257-7104.

**By signing** your name below, **you are saying** that you **understand what is being said in this form**, you have **received answers** to all your questions, you have **freely agreed to sign** this form, you have been told **who to contact** if you have questions regarding **your rights** as a participant, and you have **allowed TCU to gather, use, and share your health information** as described in the form.

**Participant’s Name (please print):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Participant’s Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_

**Investigator’s Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_

**Legal Representative of Research Participant (if applicable):**

**Legal Representative’s Name (please print):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to research participant:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that I have the legal authority as a \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (e.g., parent, legal guardian, person with legal power of attorney, etc.) to make this authorization on behalf of the research participant named above.

**Signature of the Legal Representative:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_

**Investigator’s Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_