Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

If you sign this document, you give permission to all health care providers at the Michigan State University (MSU) to use or disclose (release) your health information that identifies you for the research study described below.

Title: [Include title of the research project.]

Purpose of Research: [Provide a purpose of the research.]

DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED (RELEASED) FOR THIS RESEARCH INCLUDES: [Provide a specific and meaningful description of information to be used or disclosed for the research project. This may include, for example, all information in a medical record, results of physical examinations, medical history, lab tests, or certain health information indicating or relating to a particular condition.]

THE HEALTH INFORMATION LISTED ABOVE MAY BE USED AND/OR DISCLOSED (RELEASED) TO: [Where a covered entity conducts the research study, the Authorization must list ALL researchers and their staff plus the Human Research Protection Program or other identification, or ALL classes, of persons who will have access through the covered entity to the protected health information (PHI) for the research study (e.g., research collaborators, sponsors, and others who will have access to data that includes PHI). Examples may include, but are not limited to the following: Data coordinating centers that will receive and process PHI; Sponsors who want access to PHI or who will actually own the research data; and/or Institutional Review Boards or Data Safety and Monitoring Boards.]

You may refuse to sign this authorization and your refusal will not affect your ability to obtain treatment, however, it may affect your ability to participate in this research study.

You may change your mind and revoke (take back) this Authorization at any time, except to the extent that MSU has already acted based on this Authorization. To revoke this Authorization, you must write to: The University's Health Information Privacy Officer at Michigan State University, **Office of the General Counsel
426 Auditorium Road, Room 494, East Lansing, MI  48824.**

MSU is required by law to protect your health information. By signing this document, you authorize MSU to use and/or disclose (release) your health information for this research. Those persons who receive your health information may not be required by Federal privacy laws (such as the Privacy Rule) to protect it and may share your information with others without your permission, if permitted by laws governing them.

EXPIRATION: Your Authorization to disclose the above information expires [insert expiration date or event, such as “end of the research study; do not insert “none”].

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of individual participant or personal representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name of individual participant or personal representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If applicable, a description of personal representative’s authority to act for the individual participant

YOU WILL BE PROVIDED A COPY OF THE SIGNED FORM

A COPY OF THE SIGNED FORM MUST BE PROVIDED TO MSU