RESEARCH AUTHORIZATION

Patient Name: **ID Number:**

IRB Study Number:

TITLE

We understand that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your written authorization before we may use or disclose your protected health information for the research purposes described below. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed. Please read the information below carefully before signing this form.

USE AND DISCLOSURE COVERED BY THIS AUTHORIZATION

You or your representative should read the information on this form before signing it. A representative of New York Eye And Ear Infirmary must have filled in the answers to the questions below before providing this authorization form to you and must answer any questions you may have before you sign the form. DO NOT SIGN A BLANK FORM.

Who will disclose, receive, and/or use the information? All of the following person(s), class(es) of persons, and/or organization(s) listed in Part A and those indicated by a checked box in Part B may disclose, use, and receive the information and they may use the information and disclose it to the other parties on this list, to you or your personal representative, or as required by law.

Part A

- This **Hospital Center's** research staff and medical staff
- Every health care provider who provides services to you in connection with this study
- Any laboratories and other individuals and organizations that analyze your health information in connection with this study in accordance with the study's protocol
- The United States Food and Drug Administration and any other government agency that oversees research
- The members and staff of the hospital's affiliated Institutional Review Board
- The members and staff of the hospital's affiliated Privacy Board
- Principal Investigator:
- Study Coordinator:
- Members of the Research Team:

and the physician fellows and data managers at **NEW YORK EYE AND EAR INFIRMARY** who are assisting the Principal Investigator on this research project.

Part B

- ❑ All other research sites for this study, including each site's research staff and medical staff
- ❑ The following research sponsor(s):
- ❑ Contract Research Organization:
- ❑ Data Safety Monitoring Board/Clinical Events Committee
- ❑ Others (as described below):

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Note: The name of the sponsor or the contract research organization may change through mergers, assignments or sale of assets.

What information will be used or disclosed? The appropriate boxes must be checked below and the descriptions should be in enough detail so that you (or any organization that must disclose information pursuant to this authorization) can understand what information may be used or disclosed.

- ❑ The entire research record and any medical records held by the hospital may be used and disclosed.
- ❑ The following information:

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- ❑ HIV-related information, which includes any information indicating that you have had an HIV-related test, or have HIV infection, HIV-related illness or AIDS, or any information which could indicate that you have been potentially exposed to HIV.

Notice Concerning HIV-Related Information

If you are authorizing the release of HIV-related information, you should be aware that the recipient(s) is prohibited from redisclosing any HIV-related information without your authorization unless permitted to do so under federal or state law. You also have a right to request a list of people who may receive or use your HIV-related information without authorization. If you experience discrimination because of the release or disclosure of HIV-related information, you may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting your rights.

SPECIFIC UNDERSTANDINGS

By signing this research authorization form, you authorize the use and/or disclosure of your protected health information described above. The purpose for the uses and disclosures you are authorizing is to conduct the research project explained to you during the informed consent process and to ensure that the information relating to that research is available to all parties who may need it for research purposes. Your information may also be used as necessary for your research-related treatment, to collect payment for your medical (and research-related) treatment (when applicable), and to run the business operations of the hospital.

New York Eye And Ear staff members and physicians who are performing this research will use and disclose your information only as described earlier. However, once we disclose it to others for research purposes, **New York Eye And Ear** cannot directly control their future uses and disclosures of it. For this reason, **New York Eye And Ear** has requested that the research sponsor its agents to use your information only for this research and not for other purposes.

You have a right to refuse to sign this authorization. While your health care outside the study, the payment for your health care, and your health care benefits will not be affected if you do not sign this form, you will not be able to participate in the research described in this authorization. If you sign this authorization, you will have the right to revoke it at any time, except to the extent that the hospital has already taken action based upon your authorization or needs the information to complete analysis and reports of data for this research. This authorization will never expire unless and until you revoke it. To revoke this authorization, please write to the Principal Investigator, , at **New York Eye And Ear**, 310 East 14th Street, **New York**, New York **10003.** You will receive a copy of this form after you have signed it.

SIGNATURE

I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above.

Signature of Subject or Personal Representative	Date
Print Name of Subject or Personal Representative	Address of Subject or Personal Representative
Description of Personal Representative's Authority	Telephone Number(s) of Subject or Personal Representative

THE SUBJECT OR HIS OR HER PERSONAL REPRESENTATIVE MUST BE PROVIDED WITH A COPY OF THIS FORM AFTER IT HAS BEEN SIGNED.