

Subject Name (Last, First, Middle Initial):
Subject SSN (last 4 only):
Date of Birth:

VA Facility (Name and Address):

VA Principal Investigator (PI):
PI Contact Information:

Study Title:

Purpose of Study:

USE OF YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI):

Your individually identifiable health information is information about you that contains your health information and information that would identify you such as your name, date of birth, or other individual identifiers.

Signing this authorization is completely voluntary. However, your authorization (permission) is necessary to participate in this study.

Your individually identifiable health information used for this VA study includes the information marked below:

- Information from your VA Health Records such as diagnoses, progress notes, medications, lab or radiology findings
Specific information concerning:
alcohol abuse, drug abuse, sickle cell anemia, HIV
Demographic Information such as name, age, race
Billing or Financial Records
Photographs, Digital Images, Video, or Audio Recordings
Questionnaire, Survey, and/or Subject Diary
Other as described:

Comment [DoVA1]: GENERAL INSTRUCTIONS. PLEASE READ:
1. This form is set up in tabular format. See the "X"s for an idea of character allowances.
2. USE THE "TAB" key to maneuver through the document and within cells when you are entering text
3. Read the comment boxes throughout the document for guidance in completing the form.
4. Pre-fill all spaces and check-boxes that apply to the study.
5. For the final version of your 10-0493, remove all tutorial comment boxes and tutorial instructions.
6. Create a PDF version of your completed form. The PDF version will be used for CICERO submission and for use by the participant.
7. Submit in CICERO.
8. At the time of the informed consent/HIPAA process with a study participant:
a. Use a hard copy of the approved PDF form.
b. Fill in participant's information.
c. The participant signs Page 4.
d. If Page 5 is applicable for the study, the participant also signs Page 5.
e. If there are NO optional components to the study, then delete Page 5 completely.
See Research Hot Topic Vol.9, No.11 for details.

Comment [DoVA2]: -Fill in the study title AND its IRB number

Comment [DoVA3]: Insert a VERY BRIEF (1-2 short sentences) description. (Details should already be in ICF and should be covered during the IC process.)

Comment [DoVA4]: Mark all that apply to the study.

Comment [DoVA5]: For the "Version Date" in the footer: - Use the TAB to go into the footer and then to TAB over to the end of the underscore. -You should see a drop-down box -Choose your version date from the calendar.

**Authorization for Use & Release of Individually Identifiable Health Information for
Veterans Health Administration (VHA) Research**

| | | |
|--|---|-------------------------------------|
| Subject Name (Last, First, Middle Initial): XX | Subject SSN (last 4 only): XXXX | Date of Birth: 10/15/2015 |
|--|---|-------------------------------------|

TO BE FILLED OUT BY THE SUBJECT

Research Subject Signature. This permission (authorization) has been explained to me and I have been given the opportunity to ask questions. If I believe that my privacy rights have been compromised, I may contact the VHA facility Privacy Officer to file a verbal or written complaint.

I give my authorization (permission) for the use and disclosure of my individually identifiable health information as described in this form. I will be given a signed copy of this form for my records.

Signature of Research Subject Date

Signature of Legal Representative (if applicable) Date

To Sign for Research Subject (Attach authority to sign: Health Care Power of Attorney, Legal Guardian appointment, or Next of Kin if authorized by State Law)

Name of Legal Representative (please print)

Comment [DoVA15]: Next of kin is allowed by Maryland in the following order: *Next of Kin in the following order: (1) Spouse, (2) Adult child, (3) Parent, (4) Adult brother or sister, (5) Grandparent, (6) Adult grandchild, (7) Close friend (must complete affidavit)*

