HIPAA Authorization

The Community Healthcare System and its representatives are committed to protecting your health information. Protected health information is information in any form relating to the health care provided to you. By signing this form, you agree to permit the Community Healthcare System staff, and any member of the clinical research team to retrieve, use and disclose your health care information.

Your health care information will include any records that are retrieved and created during the extent of the research study in which you are participating in. The documents include but are not limited to:

- past, present and future health information in your medical records relevant to the research
- medical records from my primary care and consulting physicians relating to participation in research
- data created and recorded specifically for the research study

The Community Healthcare System, its staff, the sponsors of the research and their contractors will do everything possible to ensure the privacy of your personal health information. Any publications related to the research study will not contain any identifying information about you.

Participant Authorization Statement:

To the extent permitted by the applicable laws and regulations, I give my permission to release my personal health information to the following entities:

- _____, the sponsor of the research and its agents and contractors
- Members, consultants and staff of the research team
- Members, consultants and staff of the Community Healthcare System Central Institutional Review Board
- Community Healthcare System billing and quality assurance personnel
- Joint Commission of Accreditation of Health Care Organizations
- The Food and Drug Administration
- Other regulatory authorities to whom this research may be submitted

The researchers, Community Healthcare System staff, sponsor and other agents, may use and share my personal health information among themselves in order to conduct the research. My health information may be used for verification of

research procedures and data, submission to third party payors and for the assurance of safe medical care.

I understand that once my personal health information is disclosed to a third party, federal privacy laws may no longer protect the information from further disclosure.

I know that I do not have to sign this authorization; however, I have been told that if I do not sign this authorization, I may not be able to participate in this research study.

I may revoke my authorization at any time and for whatever reason. I will be asked to revoke this authorization in writing to the Research Staff at:

[Insert Complete Contact Information]

I realize that if I revoke this authorization, I will not be allowed to continue participation in the research study. I also am aware that the researchers and sponsor and their agents may continue to use and disclose any information that they have retrieved prior to my revoking the authorization.

I understand that while the research is being conducted, I will not be able to access or see my health information that was collected or created for the purposes of this research study because it may affect the integrity of the research. I, however, may access this information after the completion of the research study.

Who to contact if you have any questions about confidentiality:
If at any time before, during and after the study, you have questions about the use or disclosure of your study related information, you may contact the following person (s):

Community Healthcare System
Privacy Officer
219-836-3620

I give my authorization with no ending date, however, I understand that I may revoke this authorization at any time.

I will be given a copy of this authorization.

Participant Signature	Date and Time
Printed Name of Participant	
Legally Authorized Representative (If applicable)	Date and Time
Printed Name of Legally Authorized Representative	
Relationship of Authorized Representative to Participant	