AUTHORIZATION TO USE AND DISCLOSE
PROTECTED HEALTH INFORMATION FOR RESEARCH PURPOSES

The privacy law, Health Insurance Portability & Accountability Act (HIPAA), protects my individually identifiable health information (protected health information). The privacy law requires me to sign an authorization (or agreement) in order for researchers to be able to use or disclose my protected health information for research purposes.

I authorize Dr. Edward F. Kent Jr., MD and his research staff to use and disclose my protected health information for the purposes described below. I also permit my doctors and other health care providers to disclose my protected health information for the purposes described below.

My protected health information that may be used and disclosed includes:

- demographic information, results of physical exams, blood tests, X-rays, and other diagnostic and medical procedures as well as medical history

My protected health information will be used for:

- an Xray referral if required
- to be kept on file to contact you for future studies you may be eligible for
- to be able to conduct the research
- per protocol for all study related activities and study specific data management
- to ensure that the research meets legal, institutional or accreditation requirements
- to notify your primary care doctor of any bad effects resulting from participation in a study
- to fill a prescription

The Researchers may use and share my health information with:

- The Institutional Review Board assigned to any study I may participate in
- Government representatives, when required by law
- The Central Lab assigned to the study
- The Sponsor of the Study
- Auditing companies who may view records for quality assurance and compliance
- If applicable, The Contract Research Organization for the Study

Timber Lane Allergy & Asthma Research, LLC agrees to protect my health information by using and disclosing it only as permitted by me in this Authorization and as directed by state and federal law.

Should the health information be disclosed by the researcher, to someone outside of this study, it may no longer be covered/protected by the federal regulation HIPAA.

I do not have to sign this Authorization. If I decide not to sign the Authorization:

- It will not affect my treatment, payment or enrollment in any health plans or affect my eligibility for benefits.
- I may not be allowed to participate in the research study.

After signing the Authorization, I can change my mind and:

- Not let the researcher disclose or use my protected health information (revoke the Authorization).
- If I revoke the Authorization, I will send a written letter to: Dr. Kent to inform him of my decision.
- If I revoke this Authorization, researchers may only use and disclose the protected health information **already** collected for this research study.
- If I revoke this Authorization my protected health information may still be used and disclosed should I have an adverse event (a bad effect).
- If I change my mind and withdraw the authorization, I may not be allowed to continue to participate in the study.

I understand that I will not be allowed to review the information collected for the research until after the study is completed. When the study is over, I will have the right to access the information again.

This Authorization does not have an expiration date.

If I have not already received a copy of the Privacy Notice, I may request one. If I have any questions or concerns about my privacy rights, I should contact Timber Lane Allergy & Asthma Research, LLC at 802-864-0294, ext. 25 and ask for the Privacy Officer.

I am the subject or am authorized to act on behalf of the subject. I have read this information, and I will receive a copy of this form after it is signed.

_____	_____
Signature of research subject or *research subject's legal representative	Date
_____	_____
Printed name of research subject or *research subject's legal representative	Representative's relationship to research subject

*Please explain Representative's Relationship to Patient and include a description of Representative's Authority to act on behalf of Patient:

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