Authorization to Use or Disclose (Release) Health Information that Identifies You for a Research Study (Rvsd: 11 Nov, 2013)

PATIENT NAME: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

I hereby authorize the use or disclosure (release) of the Protected Health Information described below to be provided to or obtained by the following:

Name and Address of Individual/Facility/Company to Receive PHI	Name and Address of Individual/Facility/Company to Disclose PHI
Harvey A. Tatum, MD **1145 South Utica, Suite 514** **Tulsa, OK 74104 (Fax: 918-388-0237)**	_____ _____ _____

The health information that we may use or disclose (release) for this research includes the following:

O All information in the medical records between _____ to _____

O Medical history O Lab results O Endoscopy reports O X-ray results O Liver biopsies O Consultation O ER/Hosp

O Other:

If you sign this document, you give permission to Harvey A. Tatum, MD and the study coordinator staff at Options Health Research, LLC to use or disclose (release) your health information that identifies you for the research study described here:

STUDY SPONSOR: _____ **DISEASE STUDIED:** _____

Description of study: _____

_____

The health information listed above may be used by and/or disclosed (released) to:

Harvey A. Tatum, MD; Options Health Research study coordinators and regulatory staff; study sponsors and/or CRO staff who want access to PHI or who will actually own the research data; Institutional Review Boards or Data Safety and Monitoring Boards; and/or to those parties the study subject has given permission to by signing an "Informed Consent".

Options Health Research, LLC is required by law to protect your health information. By signing this document, you authorize Options Health Research, LLC 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.

Please note that:

- You do not have to sign this Authorization, but if you do not, you may not receive research-related treatment.
- You may change your mind and revoke (take back) this Authorization at any time. Even if you revoke this Authorization, Harvey A. Tatum, MD and the Options Health Research study coordinators may still use or disclose health information they already have obtained about you as necessary to maintain the integrity or reliability of the current research. To revoke this Authorization, you must write to: Options Health Research, Attn: Debbie Langley, RN/Administrative Vice President, 1145 South Utica, Suite 807, Tulsa, OK 74104.
- If you revoke this Authorization, you may no longer be allowed to participate in the research described in this Authorization.
- No publication or public presentation about the research described above will reveal your identity without another authorization from you.
- ***The information authorized for use or disclosure may include information which may indicate the presence of a communicable or non-communicable disease and may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, and human immunodeficiency viruses also knows as Acquired Immune Deficiency Syndrome (AIDS). Also, that this information may indicate prior or current treatment for psychological or psychiatric conditions or substance abuse.***
- The information obtained by this consent form will not be re-released to any other medical facility and will become part of the patient's research chart.
- To maintain the integrity of this research study, you generally will not have access to your personal health information related to this research until the study is complete. At the conclusion of the research and at your request, you generally will have access to your health information that Options Health Research, LLC maintains in a designated record set, which means a set of data that includes medical information used in whole or in part by Options Health Research to make decisions about individuals. Access to your health information in a designated record set is described in the Notice of Privacy Practices

provided to you by Options Health Research. If it is necessary for your care, your health information will be provided to you or your physician.

- I understand that I release Options Health Research, LLC, its employees, agents and contractors, from the responsibility for any deleterious effect the review of my clinical medical records may have upon myself or others both now and in the future. I personally accept all responsibility for my own distribution and interpretation of medical confirmation contained therein and holds blameless Options Health Research, LLC, its employees, agents and contractors for conclusions or options drawn from said records without professional knowledge assistance or review.
- Unless the purpose of this authorization is to determine payment of a claim for benefits, the requesting entity will not condition the provision of treatment, payment, enrollment in a health plan or eligibility for benefits on obtaining this authorization.

This Authorization expires at the “end of this research study” or “one (1) year from the date of signature below” – whichever is the latter.

_____ _____

Signature of participant Date

_____

Printed name of participant