JACKSON HEALTH SYSTEM
AUTHORIZATION FOR RELEASE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION FOR POSSIBLE PARTICIPATION IN A RESEARCH STUDY

Authorization to Use or Disclose (Release) Health Information that Identifies You for Possible Participation in a Research Study

(THIS IS NOT AN INFORMED CONSENT)

PATIENT NAME: _____

DATE OF BIRTH: _____

TREATMENT DATES: _____

PHONE NUMBER: _____

If you sign this document, you, _____(*insert patient name*), give permission to the Public Health Trust of Miami-Dade County, at Jackson Health System 1611 NW 12th Avenue Miami, Florida 33136, and their respective trustees, officers, employees, agents and servants, including but not limited to all clinicians involved in your care at Jackson Health System (the "Trust"), to use or disclose (release) your health information that identifies you for possible participation (recruitment) in the research study described below (*insert name and/or brief description of study*):

The health information that we may use or disclose (release) for this purpose includes (*insert information to be disclosed, example, patient name, address, phone number and medical condition or other reason why the patient may be appropriate for the study. Health information related to HIV/AIDS test results, substance abuse, sexual assault or psychiatric/psychotherapy records must be expressly stated*):

_____

_____

_____

The health information listed above may be used by and/or disclosed (released) to (*insert name of Principal Investigator or study recruitment contact*):

_____

The public health trust is required by law to protect your health information. By signing this document, you authorize the trust to use and/or disclose (release) your health information for recruitment for this research study. Those persons who receive your health information (the research study staff) may not be required by federal privacy laws (such as the privacy rule) to protect it and may share our information with others without your permission, if permitted by laws governing them.

Please note that:

- You do not have to sign this Authorization. If you do not wish to be contacted, we will not provide your contact information and medical condition to the research study staff.
- You may change your mind and revoke (take back) this Authorization at any time, except to the extent that the Trust has already acted based on this Authorization. If the Trust has not yet released your contact or other health information to the research study, your revocation will be effective for all information releases described in this Authorization.
- The Trust cannot condition your treatment, payment, enrollment or eligibility for benefits on whether or not you sign this Authorization.
- If the Trust or research study staff has acted in reliance on this Authorization, they may still use or disclose health information they already have obtained about you prior to your revocation of the Authorization. The Trust has acted in reliance on this Authorization if, prior to the date of revocation, the Trust has forwarded your contact information or other health information to the research study staff.
- To revoke this Authorization, you must write to: Chief Privacy Officer, Jackson Memorial Hospital 1500 NW 12th Avenue, Suite 102 Miami, FL 33136.
- This form does not constitute an informed consent. Should you be considered eligible to participate in this study, you will be asked to sign an informed consent.

If not revoked earlier, this Authorization automatically expires twelve months following date of patient signature.

_____
Signature of patient or patient's guardian, or patient's personal representative

_____
Printed name of patient or patient's guardian, or patient's personal representative

_____
Date Time

_____
If applicable, a description of the personal representative's authority to sign for the participant

_____
Interpreter's Signature

_____
Printed name of Interpreter

_____
Date Time