DOWNSTATE
HEALTH SCIENCES UNIVERSITY

**SUBJECT RECRUITMENT AUTHORIZATION FORM FOR:**

*Please read the information below carefully before signing this form. A representative of SUNY Downstate Health Sciences University is available to answer any questions regarding this authorization.*

Patient Name: ________________________________________ MR#: ____________________________

Address: ____________________________________________________________________________

____________________________________________________________________________

DOB: ________________ Telephone#: __________________ / _____________________
Day Evening

*Provide summary of research study being conducted at the external institution, including a statement regarding Downstate/ UHD's assistance in the recruitment phase of the study pursuant to individual patient interest/ authorization. Include statement that Downstate/ UHD is not further collaborating with the external institution on this particular study at the present time and that it is not receiving any direct/ indirect remuneration for its recruitment assistance. Include statement that Downstate/ UHD has no control over or responsibility for the use of the information once it is disclosed to the external institution and that follow up questions regarding the research study should be directed to the external institution.*

I hereby authorize SUNY Downstate Health Sciences University University Hospital at Downstate to disclose the specific information outlined below to the following physician/ research investigator at:

______________________________________________________________________________

for the purpose of contacting me regarding his/her research study:

Name: ___________________________________ Department: ___________________________________

Name of Research Study/ Protocol: ____________________________________________________________

3. The following information will be disclosed: ___________________________________________________

______________________________________________________________________________

______________________________________________________________________________

4. New York State regulations [ NY Public Health Law §2782(1)(b) ] require a special authorization for release of information regarding mental health, any HIV- related condition (including HIV-related test, illness, AIDS or any information indicating potential exposure to HIV) or drug and alcohol abuse.
__ Do not authorize release of this information.
__ Authorize release of this information; specify the information to be released ___________________

______________________________________________________________________________

I understand that this authorization will expire at the end of the subject recruitment phase of the research study *(state alternate expiration date, if this is not accurate)*, unless otherwise stated:
Expiration Date: _____________________

*By signing this authorization form, you authorize the use or disclosure of your protected health information as described above. This information may be re-disclosed if the recipient(s) described on this form is not required by law to protect the privacy of the information.*

*If you are authorizing the release of HIV-related information, you should be aware that the recipient(s) is prohibited from re-disclosing any HIV-related information without your authorization, unless permitted to do so under federal or state law. If you experience discrimination because of the release of disclosure of HIV-related information, you may contact the New York State Division of Human Rights at (212) 870-8624 or the New York City Commission of Human Rights at (212) 566-5493. These agencies are responsible for protecting your rights.*

*You have a right to refuse to sign this authorization. Your healthcare, the payment for your healthcare and your healthcare benefits will not be affected if you do not sign this form.*

*You have a right to receive a copy of this form after you sign it.*

*You have the right to revoke this authorization at any time, except to the extent that action has already been taken based upon your authorization. To revoke this authorization, please write to:*

*Name:*_____________________________________________________

*Address:*__________________________________________________________________________________

*Telephone:*________________________________________________________________________________

________________________________ ________________________________________ __________________
Print Name Of Patient Signature of Patient Date