DOWNSTATE
HEALTH SCIENCES UNIVERSITY

SUBJECT RECRUITMENT AUTHORIZATION FORM

PLEASE NOTE: A summary of the basic information regarding the research study must be provided to the individual and must accompany this form.

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) _____ (Eve)

I hereby authorize UHD to disclose my information to the physician(s) / researcher(s) conducting the following research study at SUNY Downstate for the purpose of contacting me regarding participation in the research:

Name: _____ Department: _____

Name of Research Study/ Protocol: _____

1. The following information will be disclosed:

2. 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, 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:

_____ _____ _____

Print Name of Patient Signature of Patient Date