This is a template form for reference purposes only. Please use it as a guide and submit your completed form on your organization's letterhead.

RESEARCH REVIEW COMMITTEE

HIPAA AUTHORIZATION FOR USE AND DISCLOSURE OF CLINICAL INFORMATION, PHOTOGRAPHS, VIDEO IMAGES, AND TESTIMONIALS FOR RESEARCH PURPOSES

I, _____, (Individual Served/Parent/Legal Representative)hereby authorize [Organization Name] to use and disclose information collected during the course of routine clinical services provided to:

_____

(Individual Served) for research, educational, and scientific purposes as described below.

Purpose of Use

The purpose of this authorization is to permit [Organization Name] and its approved researchers to use information collected during routine clinical care to:

- Evaluate treatment effectiveness;
- Improve service delivery and clinical outcomes;
- Advance scientific and professional knowledge;
- Conduct educational, quality improvement, and research activities; and
- Publish or present research findings.

Research Disclosure

As part of providing healthcare services [Organization Name] may collect health information about you or your child during assessment, treatment, care coordination, billing, quality improvement activities, and other healthcare operations.

From time to time, information collected during clinical care may be reviewed to determine whether it could contribute to research intended to improve healthcare services, treatment outcomes, or scientific knowledge.

Your decision to receive treatment is not conditioned on participation in any research study.

Information Subject to Authorization

I understand that information collected during routine assessment, treatment, therapy sessions, service delivery, care coordination, and other healthcare operations may be used for research purposes. Such information may include:

- Clinical records and treatment information;
- Assessment results and outcome measures;
- Behavioral, educational, and developmental data;
- Photographic images;
- Video recordings;
- Audio recordings;
- Testimonials; and
- Other information collected during the provision of services.

Future Research Use of Information

Information collected during treatment may be considered for future research purposes. If identifiable health information is proposed for use or disclosure in a research study, additional permissions, consents, authorizations, or approvals may be required unless otherwise permitted by applicable law.

You or your child's identifiable health information will not be used for research without appropriate authorization, consent, waiver, or other legal basis as required by federal and state law and applicable regulatory requirements

Protection of Privacy

To the extent possible, information used for research will be de-identified or coded to protect privacy. However, in some circumstances, identifiable information may be reviewed or used when permitted by law, approved by a Research Review Committee (RRC), Institutional Review Board (IRB) or other applicable oversight body, and authorized by the participant or legally authorized representative when required. In other words, if information is unable to be de-identified or coded to protect privacy, it will not be used unless it has received further approval by a RRC, IRB, or other applicable oversight body. In this case, I would be provided with informed consent documentation and further information on the way in which that information would be used.

I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA once disclosed to parties not covered by HIPAA.

Voluntary Authorization

I understand that:

- Participation in research is voluntary.
- Refusal to sign this authorization will not affect eligibility for services, treatment, payment, or benefits.
- [Organization Name] may not condition treatment on whether I sign this authorization.
- Additional study-specific consent and HIPAA authorization may be required for certain research projects involving identifiable information.

Right to Revoke

I understand that I may revoke this authorization at any time by providing written notice to [Organization Name], except to the extent that action has already been taken in reliance on this authorization.

Expiration

This authorization shall remain in effect until revoked in writing, upon termination of services, or for ten (10) years from the date of signature, whichever occurs first, unless otherwise required by law or specific research protocols

Research Oversight

I understand that research activities may be reviewed and approved by a Research Review Committee, Institutional Review Board (IRB), or other regulatory oversight body to ensure compliance with applicable laws and ethical standards.

Minors and Legally Authorized Representatives

For patients under the age of 16 or individuals who lack legal capacity to provide informed consent, permission for participation in research may be obtained from a parent, legal guardian, or other legally authorized representative, as required by law.

When appropriate, minors may also be asked to provide assent for participation in research activities.

Authorization

By signing below, I acknowledge that I have read and understand this authorization and voluntarily permit the use and disclosure of the information described above for research purposes.

☐ I give permission to use the information explained above for research purposes, including photographs and videos of my child.

☐ I give permission to use the information explained above for research purposes EXCEPT for the use of photographs and videos of my child. I do not consent to photographs or videos being utilized for research purposes.

_____ _____

Signature of Individual Served or Legal Representative Date

_____

Printed Name

_____

Relationship to Individual Served

_____

Witness Signature Date

_____

Printed Name of Witness