

**HIPAA¹ AUTHORIZATION TO USE AND DISCLOSE
INDIVIDUAL HEALTH INFORMATION FOR RESEARCH PURPOSES**

1. Purpose. As a research participant, I authorize Bruce H. Alexander, Ph.D. and his research staff to use my individual health information for the purpose of conducting the research project entitled: US Radiologic Technologists Study, HSC: 8005M02489. The information obtained from medical records will be used to evaluate the possible health risks associated with occupational and environmental exposures. The survey is authorized under Section 411 of the Public Health Service Act (42 USC 285a).

2. Individual Health Information to be Used or Disclosed. My individual health information that may be used or disclosed to conduct this research may include: demographic information and medical records from a biopsy, ultrasound, or surgical procedure, radiology or imaging studies, radiotherapy or chemotherapy.

3. Parties Who May Disclose My Individual Health Information. The researcher and the researcher's staff may obtain my individual health information from the hospital(s) or medical facility where I have been diagnosed or treated for multiple sclerosis or a related condition:

Hospital: _____

Other Medical Facility or Clinic: _____

Physician: _____

4. Parties Who May Receive or Use My Individual Health Information. The individual health information disclosed by parties listed in item 3 and information disclosed by me during the course of the research may be received and used by Bruce H. Alexander, Ph.D. and his research staff and collaborating researchers at the National Cancer Institute and University of Washington to conduct the data analysis for this research study. Any published results from this survey will be reported in statistical summaries only, and will never include a participant's name.

5. Right to Refuse to Sign this Authorization. I do not have to sign this Authorization. If I decide not to sign the Authorization, I may not be allowed to participate in the study. However, my decision not to sign this authorization will not affect any treatment, payment, or enrollment in health plans or eligibility for benefits.

6. Right to Revoke. I can change my mind and withdraw this authorization at any time by sending a written notice to: Bruce H. Alexander, Ph.D., University of Minnesota, MMC 807, 420 Delaware St SE, Minneapolis, MN 55455, to inform him of my decision. If I withdraw this authorization, the researcher may only use and disclose the protected health information already collected for this research study. No further health information about me will be collected by or disclosed to the researcher for this study.

7. Potential for Re-disclosure. Once my health information is disclosed under this authorization, there is a potential that it will be re-disclosed outside this study and no longer covered by HIPAA. However, I understand that the researchers from the University of Minnesota and the National Cancer Institute will protect my privacy under the Privacy Act and confidentiality through a Certificate of Confidentiality (see Page 2).

¹ HIPAA is the Health Insurance Portability and Accountability Act of 1996, a federal law related to privacy of health information.

In addition, the Institutional Review Boards of the University of Minnesota and the National Cancer Institute (the committees that review studies to be sure that the rights and safety of study participants are protected) are very careful to protect your privacy and limit the disclosure of identifying information about you.

Privacy Act: All information you provide will be kept private under The Privacy Act and will not be disclosed to anyone but the researchers conducting this study, except as otherwise required by law. Any published results from the study will be reported in statistical summaries only and will never include a participant's name. Your participation in the study is completely voluntary and failure to answer any particular question or the information collection as a whole will not affect your future contacts with the University of Minnesota, the American Registry of Radiologic Technologists, or the National Institutes of Health.

Certificate of Confidentiality: To help us further protect your privacy, we have obtained a Certificate of Confidentiality from the National Institutes of Health. With this Certificate, the researchers cannot be forced to disclose information that may identify you, even by a court subpoena, in any federal, state, or local civil, criminal, administrative, legislative, or other proceedings. The researchers will use the Certificate to resist any demands for information that would identify you, except as follows. The Certificate cannot be used to resist a demand for information from personnel of the United States Government that is used for auditing or evaluation of Federally funded projects or for information that must be disclosed in order to meet the requirements of the federal Food and Drug Administration (FDA). You should understand that a Certificate of Confidentiality does not prevent you or a member of your family from voluntarily releasing information about yourself or your involvement in this research. If an insurer, employer, or other person obtains your written consent to receive research information, then the researchers may not use the Certificate to withhold that information. The researchers will not make any voluntary disclosures.

This authorization does not have an expiration date.

If you have any questions, please direct them to Dr. Alexander at the University of Minnesota, MMC 807, 420 Delaware St. SE, Minneapolis, Minnesota, 55455. You may call the study office at 612-625-1151.

I am the research participant or personal representative authorized to act on behalf of the participant.

I have read this information, and I will receive a copy of this authorization form after it is signed.

Photocopy is valid as original.

signature of research participant or research participant's
personal representative

date

printed name of research participant or research participant's
personal representative

description of personal representative's authority to act on behalf
of the research participant