

**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 radiation 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 cancer 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 RTI International 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.

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

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 the researchers from the University of Minnesota, the National Cancer Institute and RTI International will abide by the promises of privacy under the Privacy Act they have made. In addition, the University's Institutional Review Board (the committee that reviews studies to be sure that the rights and safety of study participants are protected) is very careful to protect your privacy and limit the disclosure of identifying information about you.

7A. Also, there are other laws that may require my individual health information to be disclosed for public purposes. Examples include potential disclosures if required for mandated reporting of abuse or neglect, judicial proceedings, health oversight activities and public health measures.

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