ARROWHEAD REGIONAL MEDICAL CENTER

The Heart of a Healthy Community

Institutional Review Board

Authorization for Use or Disclosure of Protected Health Information (PHI)

Arrowhead Regional Medical Center, Office of Research and Grants
400 N Pepper Ave, Colton, CA 92324
Phone: 909-580-6336 / Email: ARMC-IRB@armc.sbcounty.gov

TITLE OF STUDY:	[Enter Title]
PRINCIPAL INVESTIGATOR:	[Enter PI Name]
Others who will use, collect, or share PHI:	[Enter other names and groups]

The study named above may be performed only by using personal information relating to your health. National and international data protection regulations give you the right to control the use of your medical information. Therefore, by signing this form, you specifically authorize your medical information to be used or shared as described below.

The following personal information, considered "Protected Health Information" (PHI) is needed to conduct this study and may include, but is not limited to: name, address, telephone number, date of birth, government-issued identification number, and medical records and charts, including the results of all tests and procedures performed.

The individual(s) listed above will use or share this PHI in the course of this study with the Institutional Review Board (IRB) and the Office of Research and Grants of Arrowhead Regional Medical Center, the sponsor of the study (name) and its affiliates, government agencies such as the Food and Drug Administration (FDA), other research sites involved in this study, health care providers who provide services to you in connection with this study, central labs, central review centers and central reviewers.

The main reason for sharing this information is to be able to conduct the study as described earlier in the consent form. In addition, it is shared to ensure that the study meets legal, institutional, and accreditation standards. Information may also be shared to report adverse events or situations that may help prevent placing other individuals at risk.

All reasonable efforts will be used to protect the confidentiality of your PHI, which may be shared with others to support this study, to carry out their responsibilities, to conduct public health reporting and to comply with the law as applicable. Those who receive the PHI may share with others if they are required by law, and they may share it with others who may not

be required to follow national and international "protected health information" (PHI) regulations such as the federal privacy rule.

Subject to any legal limitations, you have the right to access any protected health information created during this study. You may request this information from the Principal Investigator named above but it will only become available after the study analyses are complete.

This authorization does not expire, and will continue indefinitely unless you notify the researchers that you wish to revoke it.

You may change your mind about this authorization at any time. If this happens, you must withdraw your permission in writing. Beginning on the date you withdraw your permission, no new personal health information will be used for this study. However, study personnel may continue to use the health information that was provided before you withdrew your permission. If you sign this form and enter the study, but later change your mind and withdraw your permission, you will be removed from the study at that time. To withdraw your permission, please contact the Principal Investigator or study personnel at [*insert phone number, including area code*].

You may refuse to sign this authorization. Refusing to sign will not affect the present or future care you receive at this institution and will not cause any penalty or loss of benefits to which you are entitled. However, if you do not sign this authorization form, you will not be able to take part in the study for which you are being considered. You will receive a copy of this signed and dated authorization prior to your participation in this study.

I agree that my personal health information may be used for the study purposes described in this form.

Signature of Patient *or* Patient's Legal Representative	Date
Printed Name of Legal Representative (if any)	Representative's Authority to Act for Patient
Signature of Investigator Obtaining Authorization	Date