HIPAA Authorization

For the Use of Patient Health Information for Research

Research Title:	Helping Patients and Physicians Choose the appropriate surgery for End stage hallux rigidus
Lead researcher:	William Ledoux
Institution of lead researcher:	Harborview Medical Center

A. Purpose of this form

The purpose of this form is to give your permission to the research team to obtain and use your patient information. Your patient information will be used to do the research named above.

State and federal privacy laws protect your patient information. These laws say that, in most cases, your health care provider can release your identifiable patient information to the research team only if you give permission by signing this form.

You do not have to sign this permission form. If you do not, you will not be allowed to join the research study. Your decision to not sign this permission will not affect any other treatment, health care, enrollment in health plans or eligibility for benefits.

B. The patient information that will be obtained and used

"Patient information" means the health information in your medical or other healthcare records. It also includes information in your records that can identify you. For example, it can include your name, address, phone number, birthdate, and medical record number.

1. Location of patient information

By signing this form you are giving permission to the following organization(s) to disclose your patient information for this research.

- UW Medicine (includes University of Washington Medical Center & Clinics; Harborview Medical Center & Clinics; UW Medicine Neighborhood Clinics; University of Washington Sports Medicine Clinic; UW Medicine Eastside Specialty Center; Hall Health Primary Care Center; University of Washington Physicians)

2. Patient information that will be released for research use

This permission is for the health care provided to you during the following time period from the time of your first visit for your foot until the end of this research study.]

The specific information that will be released and used for this research is described below*:*

- Hospital discharge summary
- Radiology records
- Medical history / treatment
- Consultation
- Radiology films (like X-rays or CT scans)
- Laboratory / diagnostic tests
- EKG report

- EEG report
- Pathology reports
- Operative report (about an operation)
- Diagnostic imaging report

C. How your patient information will be used

1. Who may receive your patient information

    - The sponsor of this research. “Sponsor” includes any persons or companies that are working with or for the sponsor, or that are owned by the sponsor
    - The U.S. Food and Drug Administration (FDA)
    - Department of Health and Human Services (DHHS) agencies
    - Governmental agencies to whom certain diseases (reportable diseases) must be reported
    - Western Institution Review Board (WIRB)
    - Institutional oversight review offices at the research site, the UW, or state
    - Data & Safety Monitoring Boards, or other entities.
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      Why your patient information will be used and/or given to others

    - To do the research
    - To study the results, and
    - To see if the research was done right

If the results of this study are made public, information that identifies you will not be used.
The researcher will use your patient information only in the ways that are described in the research consent form that you sign and as described in this HIPAA Authorization.

You can ask questions about what the research team will do with your information and how they will protect it.

The privacy laws do not always require the receiver of your information to keep your information confidential. After your information has been given to others, there is a risk that it could be shared without your permission.

You have the right to obtain your patient information in your healthcare record.The study procedures do not include a plan to share your research results, though you may be able to request them through the Washington State Public Records request system after the study is done.

D. Expiration

This permission for the researchers to obtain your patient information

ends when the research ends and any required monitoring of the study is finished.

E. Canceling your permission

You may change your mind at any time. To take back your permission, you must send your **written** request to:

William Ledoux, HMC, 325 9th Ave, Seattle Wa 98104

If you take back your permission, the research team may still keep and use any patient information about you that they already have. But they can't obtain more health information about you for this research unless it is required by a federal agency that is monitoring the research.

If you take back your permission, you will need to leave the research study. Changing your mind will not affect any other treatment, payment, health care, enrollment in health plans or eligibility for benefits.

F. Giving permission

I have read this HIPAA Authorization form describing how my patient information will be used. I have had a chance to ask questions about the use of my patient information and I have received answers to my questions. I agree to the use of my patient information for this research.

Printed Name of Research Subject	Birthdate
Signature of Research Subject	Date of signature

You will receive a copy of this signed form. Please keep it with your personal records.