SUNY DOWNSTATE Medical Center

AUTHORIZATION FORM- SUBJECT RECRUITMENT

Please read the information below carefully before signing this form. A representative of SUNY Downstate Medical Center is available to answer any questions regarding this authorization.

Patient Name: _____ MR#: _____

Address: _____

_____

DOB: _____ Telephone#: _____ (Day) _____ (Eve)

I hereby authorize University Hospital of Brooklyn Clinical Laboratory Department to disclose my information to the following physician/ research investigator at SUNY Downstate Medical Center for the purpose of contacting me regarding his/her research study:

Name: _____ Department: _____

Name of Research Study/ Protocol: _____

3. The following information will be disclosed: _____

_____

_____

4. New York State regulations [NY Public Health Law §2782(1)(b)] require a special authorization for release of information regarding mental health, any HIV- related condition (including HIV-related test, illness, AIDS or any information indicating potential exposure to HIV) or drug and alcohol abuse.
__ Do not authorize release of this information.
__ Authorize release of this information; specify the information to be released _____

_____

I understand that this authorization will expire at the end of the subject recruitment phase of the research study, unless otherwise stated: Expiration Date: _____

By signing this authorization form, you authorize the use or disclosure of your protected health information as described above. This information may be re-disclosed if the recipient(s) described on this form is not required by law to protect the privacy of the information.
If you are authorizing the release of HIV-related information, you should be aware that the recipient(s) is prohibited from re-disclosing any HIV-related information without your authorization, unless permitted to do so under federal or state law. If you experience discrimination because of the release of disclosure of HIV-related information, you may contact the New York State Division of Human Rights at (212) 870-8624 or the New York City Commission of Human Rights at (212) 566-5493. These agencies are responsible for protecting your rights.
You have a right to refuse to sign this authorization. Your healthcare, the payment for your healthcare and your healthcare benefits will not be affected if you do not sign this form.
You have a right to receive a copy of this form after you sign it.
You have the right to revoke this authorization at any time, except to the extent that action has already been taken based upon your authorization. To revoke this authorization, please write to:

_____ _____ _____
Print Name Of Patient Signature of Patient Date