RIN: _____
IRB Protocol #: _____

AUTHORIZATION FOR THE RELEASE AND USE OF PRIVATE HEALTH INFORMATION (PHI)

Project Title:
PI Name/Contact Information:

You have rights regarding the privacy of your medical information collected before and during this research. This medical information, called "protected health information," (PHI), could include, depending on the nature of this research, demographic information (like your biological sex and age), your medical history, and your assessment, diagnoses, and treatment. The PHI that will be accessed for this study is specifically detailed below.

By signing this document, you give permission for the release and use of your identifiable Private Health Information (PHI). The PHI that will be released for this study includes the following:

1. Your age, biological sex, education level, marital status, and ethnicity
2. Your psychological and psychiatric assessment data and reports
3. Number of previous residential treatment programs and psychiatric hospitalizations and associated data
4. Your psychosocial and medical history
5. Your diagnoses
6. Your treatment notes and plans

Your PHI will be shared, as necessary, with the people or groups listed below. All of these persons or groups are obligated to protect your PHI.

1. _____ [entity providing PHI]
2. Principal Investigator and research team [entity receiving PHI]
3. Pepperdine University Institutional Review Board [entity receiving PHI]

The above-listed individual(s) and/or group(s)agree to protect your health information and will only share this information as described within this research Authorization form. The only reason that your information will be shared with anyone other than the researchers without your permission is if required to do so by law, as directed in the HIPAA Privacy Rule.

The participant must read and initial the following statements:

_____ I understand that my decision to release my PHI is voluntary and _____ may not withhold treatment, payment, enrollment, and/or eligibility for benefits whether or not I sign this Authorization.

_____ I understand that I may change my mind and take back this Authorization at any time. PHI already released by _____ to Principal Investigator, research team, and/or Pepperdine University IRB; however, cannot be taken back at that time. Any information already released under this Authorization may be used.

You may cancel your authorization for further collection of PHI for use in this research at any time by contacting the Principal Investigator in writing. However, the PHI which is included in the research data obtained to date may still be used. If you cancel this authorization, you will no longer be able to participate in this research. To revoke this Authorization, please write to: Dr. Judy Ho, Pepperdine University, 6100 Center Drive, Los Angeles, CA 90045.

You are authorizing us to collect, use and/or disclose your PHI for as long as the research study is being conducted. You will be provided a copy of this form for your records.

_____
Name of Participant

_____ _____
Signature of Participant Date