**HIPAA language for consent form:**

**Authorization to Use or Disclose Health Information that Identifies You for a Research Study**

If you sign this document, you give permission to [Enter name or other identification of specific health care provider(s) or description of classes of persons, e.g., all doctors, all health care providers] at [Enter name of covered entity or entities] to use or disclose (release) your health information that identifies you for the research study.

The health information that we may use or disclose (release) for this research includes:

[Provide a description of information to be used or disclosed for the research project. This may include, for example, all information in a medical record, results of physical examinations, medical history, lab tests, or certain health information indicating or relating to a particular condition.]

The health information listed above may be used by and/or disclosed (released) to: [Name or class of persons involved in the research; i.e., researchers and their staff \*]

The “covered components” of Montclair State University are required by law to protect your health information. By signing this document, you authorize the covered components of Montclair State University to use and/or disclose (release) your health information for this research. Those persons who receive your health information may not be required by Federal privacy laws (such as the Privacy Rule) to protect it and may share your information with others without your permission, if permitted by laws governing them.

You do not have to sign this Authorization, but if you do not, you may not receive research-related treatment.

You may change your mind and revoke (take back) this Authorization at any time, except to the extent that the covered components of the Montclair State University have already acted based on this Authorization. To revoke this Authorization, you must contact the Privacy Officer at Montclair State University at:

This Authorization does not have an expiration date. [or as appropriate, insert expiration date or event, such as “end of the research study.”]

(\*Include prior to the signature)

**Statement of Consent and HIPAA authorization**

I have read the consent and HIPAA authorization form and fully understand the purpose, procedures, risks, benefits and alternatives. I am aware that any questions I have can be answered prior to choosing to participate. I am not waiving (giving up) any of my legal rights by agreeing to take part in this research s

tudy and I am aware that I can stop being in the study at any time. I will be given a copy of this form to keep for my records.