

Authorization for Clinical Research Database

New legislation regarding the privacy of your protected health information ("PHI") became effective April 14, 2003. This law is known as the Health Insurance Portability and Accountability Act ("HIPAA"). This law requires that all healthcare providers, including National Jewish, maintain the privacy of individuals' health information and provides individuals with a notice of their rights and a description of how their PHI is used by the organization.

In order for National Jewish to contact you about your interest and eligibility for research studies, we must have your authorization to do so. Returning this form to National Jewish will allow us to periodically access your PHI in our clinical database and to contact you about clinical research studies for up to four (4) years from the date you sign this form.

I authorize the retention of the following information:

- | | |
|--|---|
| <input type="checkbox"/> Medical History | <input type="checkbox"/> Pulmonary Function Results |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Skin Test Results |
| <input type="checkbox"/> Demographic Info. (name, address, phone, etc) | <input type="checkbox"/> Diagnosis |
| <input type="checkbox"/> Other (Please Specify): _____ | |

Only National Jewish clinical research staff, including principal investigators, sub-investigators, clinical research coordinators, and patient recruiters, will have access to your records, unless otherwise required by law. Any information about you will be protected in a secure location, with limited access by the research staff, as described above. You may revoke this authorization in writing at anytime by contacting:

J. Verne Singleton
National Jewish Medical and Research Center
1400 Jackson Street
Denver, CO 80206

Authorized individuals may access and disclose your PHI permitted by this authorization until you have revoked it or it has expired. If you revoke the authorization, the people authorized to use and disclose your PHI may use the information collected, prior to the revocation date. Treatment, payment, enrollment and eligibility for benefits at National Jewish are not dependent on whether you sign this Authorization. Although we will not disclose your PHI to third parties without your specific authorization, we are required to inform you that after your PHI has been accessed by the research staff mentioned above, it might be disclosed and no longer protected by HIPAA. You will receive a copy of this authorization.

I agree to be in your confidential database and give permission for you to contact me about research studies until the expiration date on December 31, 2006.

Yes No

Patient Name: _____ Date of Birth: _____

Parent/Legal Guardian Name (if applicable): _____

Mailing Address: _____

Home Phone: _____ Work Phone: _____

Signature: _____ Date: _____

Thank you for your interest in our clinical research studies.