

New York State Psychiatric Institute (NYSPI)
Authorization to Use or Disclose Health Information during a Research Study
(Child Version)

Protocol Number:

Principal Investigator:

Name of Study:

Before researchers can use or share any identifiable health information (“Health Information”) about your child as part of the above study (the “Research”), the New York State Psychiatric Institute (NYSPI) is required to obtain your authorization. You agree to allow the following individuals and entities to use and disclose Health Information about your child as described below:

- New York State Psychiatric Institute (NYSPI), your child’s doctors and other health care providers, if any, and
- The Principal Investigator and his/her staff (together “Researchers”). Researchers may include staff of NYSPI, the New York State Office of Mental Health (OMH), Research Foundation for Mental Hygiene, Inc. (RFMH), and Columbia University (CU), provided such staff is a part of the study, and
- Providers of services for the Research at CU, NYSPI and/or RFMH, such as MRI or PET, or Central Reference Laboratories (NKI), if indicated in the consent form.

1. The Health Information that may be used and disclosed for this Research includes:

All information collected during the Research as told to you in the Informed Consent Form.

Health Information in your child’s clinical research record which includes the results of physical exams, medical and psychiatric history, laboratory or diagnostic tests, or Health Information relating to a particular condition that is related to the Research.

Additional information may include:

2. The Health Information listed above may be used and disclosed to:

Researchers and their staff at the following organizations involved with this Research:

The Sponsor of the Research,

and its agents and contractors (together, “Sponsor”); and

Representatives of regulatory and government agencies, institutional review boards, representatives of the Researchers and their institutions to the level needed to carry out their responsibilities related to the conduct of the research.

Private laboratories and other persons and organizations that analyze your child’s health information in connection with this study

Other (family members or significant others, study buddies, outside agencies etc.) Specify:

3. By giving permission to release your child’s Health Information as described above, you understand that your child’s Health Information may be disclosed to individuals or entities which are not required to comply with the federal and state privacy laws which govern the use and disclosure of personal Health Information by NYSPI. This means that once your child’s Health

Information has been disclosed to a third party which does not have to follow these laws (e.g., a drug company or the Sponsor of the Research), it may no longer be protected under the HIPAA or NYS Mental Hygiene Law requirements but is subject to the terms of the consent form and may be subject to other state or federal privacy laws or regulations.

4. Please note that:

- You do not have to sign this Authorization form, but if you do not, your child may not be able to participate in the study or receive study related care. You may change your mind at any time and for any reason. If you do so, your child may no longer be allowed to participate in the study. If you withdraw this Authorization the research staff and the Sponsor, if this is sponsored research, may still use or disclose Health Information containing identifying information they already have collected about your child as needed to maintain the reliability of the research. Any request to withdraw this Authorization must be made in writing to (enter name and contact information below):

- While the Research is going on, you may not be allowed to review the Health Information in your child’s clinical research record that has been created or collected by NYSPI. When this research has been completed you may be allowed to see this information. If it is needed for your child’s care, your child's Health Information will be given to you or your child’s Doctor.

5. This Authorization does not have an end date.

6. You will be given a copy of this form after you have signed it.

I agree to the use and disclosure of Health Information about me as described above:

Signature of Parent/ Legal Representative

Date

Printed Name of Parent/Legal Representative

Name of child

We also ask you or your legal representative to initial the statements below:

I have received a copy of the NYSPI/OMH Notice of Privacy Practices.