AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION FOR RESEARCH PURPOSES

Information About the Research Study

Drs. Reisine and Schensul and their staff are conducting a research study called Changing Oral Health Norms and Hygiene Practices among Vulnerable Older Adults. The purpose of the study is to understand oral health beliefs and behaviors of older adults and to help them improve their oral health.

Voluntary Status

Because of a federal law called the Health Insurance Portability & Accountability Act (HIPAA), we must get your permission to use and disclose your identifiable health information for this research study. This form is used to document that permission. Because of HIPAA you must also receive a copy of the Health Center's rules about privacy.

Your decision whether to give permission is voluntary. The only consequence of not granting permission is that you will not be allowed to participate in this research study.

Information That Will be Used / Disclosed

The following information about you may be used and disclosed for the purpose of this research study:

- demographic information
- results of dental exams
- medical and dental histories

How the Information Will be Used / Disclosed

The information noted above will be used and disclosed for the following purpose(s):

- to describe the characteristics of the participants in the study
- to monitor your oral health status
- to assess the relationships between demographic data and oral health outcomes
- to determine whether you should be excluded from the dental exam

People/Offices That Will Have Access to Your Information

The following people/entities may use and disclose your protected health information.

- Drs. Reisine and Schensul and their staff
- The Health Center's Institutional Review Board and Human Subjects Protection Office and Office of Research Compliance
- Hospital or University of Connecticut Health Center representatives.
- Government representatives, such as the Food & Drug Administration or Office for Human Research Protections; when required by law.
- The National Institute of Dental and Craniofacial Resesarch, the sponsor of this study

The researchers and staff agree to protect your information by using and disclosing it only as stated in this document and as directed by state and federal law. Once your health information has been disclosed to anyone outside of this institution, the information may no longer be protected under this authorization.

Reasons to share your information are to be able to conduct research, and to ensure that the research meets legal, institutional and/or accreditation requirements.

Right to Access Information
You will not be allowed to review the information collected for this research project until the collection of information is complete and/or the study is complete.

Expiration of Permission
Your permission to use and disclose your protected health information does not have an expiration date

How to Withdraw Permission
You can withdraw your permission at any time by sending a letter to Dr. Susan Reisine, 263 Farmington Ave, Farmington, CT 06030, to inform her. If you withdraw your permission you will no longer be allowed to participate in this study. If you withdraw your permission the PIs and their staff will no longer be able to use and disclose your protected health information. There are exceptions to this. For example, the researchers may continue to use and disclose the protected health information that was collected for the research study prior to receiving the request to withdraw your permission.

Questions or Complaints
If you have any questions, concerns or complaints about your privacy rights, you may write to the Director of Patient Relations at the University of Connecticut Health Center, 263 Farmington Avenue, Farmington CT 06030-1112. If you have a complaint, you may also write to the Federal Department of Health and Human Services (DHHS) at DHHS Regional Manager, Office of Civil Rights, U.S. Dept. of Health and Human Services Government Center, J.F. Kennedy Federal Building, Room 1875, Boston MA 02203. Complaints should be sent within 180 days of when you knew, or should have known, of the problem.

State of Connecticut Requirement
In this study we are not asking for information about AIDS, HIV infection, behavioral health services, psychiatric care, or treatment for alcohol and/or drug abuse. If this type of information pertains to you, there is a slight chance that it may be inadvertently disclosed during the course of the study. The State of Connecticut requires that any release of this type of information be specifically authorized. By signing this dual-purpose authorization you acknowledge that there is a chance that such information may be disclosed.

Permission for Use and Disclosure of Information
You are a voluntary participant in this research study, or you are authorized to act on behalf of the participant and are doing so voluntarily. By signing you acknowledge that you have read this form, had the opportunity to ask questions, and obtain satisfactory explanations, and that you authorize the use and disclosure of protected health information as described in this form. You will receive a copy of this form after it is signed.

_____

Signature of the research participant or the research participant's legal representative*. Date

_____

Printed name of the research participant **and** if applicable the participant's legal representative*

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Representative's relationship to the research subject

*Please provide documentation of your status as an authorized representative

The University of Connecticut Health Center's Notice of Privacy Practice is provided to all patients and research participants. The Notice is available on-line at http://health.uchc.edu/privacy/index.htm. The Notice explains how your medical information may be used and disclosed and how you can get access to this information.

Please initial the appropriate choice:

_____You have previously received the University of Connecticut Health Center's Notice of Privacy Practice that explains your rights and the policy of the institution.

_____You have been provided with a hard copy of the University of Connecticut Health Center's Notice of Privacy Practice by the researcher(s) and have been given the opportunity to read it and ask questions prior to signing this form.

There may be studies conducted in the future for which you may be an eligible participant. Please initial your preference.

_____You **give** permission to Drs. Reisine and Schensul or their designated staff to add your name and address to a mailing list to receive information about other studies we may conduct.

_____You **do not give** permission to be contacted about future studies for which you may be an eligible participant.
