HIPAA Authorization for the Use of Personal Health Information for Research

Research Title:	Midlife Cognitive Change and Risk of Cognitive Decline
Lead researcher:	Sherry Willis, PhD
Institution of lead researcher:	University of Washington
Other researchers	Thomas Montine, MD Department of Pathology University of Washington

A. Purpose of this form

The purpose of this form is to give your permission to the research team to obtain and use your personal health information. Your personal health information will be used to do the research named above.

State and federal privacy laws protect your personal health information. These laws say that, in most cases, your health care provider can release your identifiable personal health information to the research team only if you give permission by signing this form.

You do not have to sign this permission form. If you do not, you will be allowed to join the research study. Your decision to not sign this permission will not affect any other treatment, payment, enrollment in health plans or eligibility for benefits.

B. The personal health information that will be obtained and used

"Personal health information" means the health information in your medical or other healthcare records. It also includes information in your records that can identify you. For example, it can include your name, address, phone number, birthdate, and medical record number. It also includes information collected as part of this research study.

1. Location of personal health information

By signing this form you are giving permission to the following organization(s) to disclose your personal health information for this research

Group Health Cooperative

_____

2. Personal health information that will be released for research use

This permission is for the health care provided to you during the following time period: From the time you jointed the study until the end of this research study

The specific information that will be released and used for this research is described below:

- Utilization records, including primary care visits, hospitalizations, diagnosis codes, outpatient costs, enrollment data
- Pharmacy records

C. How your personal health information will be used

The researcher will use your personal health information only in the ways that are described in the research consent form that you sign and as described here.

The research consent form describes who will have access to your information. It also describes how your information will be protected. You can ask questions about what the research team will do with your information and how they will protect it.

The privacy laws do not always require the receiver of your information to keep your information confidential. After your information has been given to others, there is a risk that it could be shared without your permission.

D. Expiration

This permission for the researchers to obtain your patient information as described above

ends when the research study ends

E. Canceling your permission

You may change your mind at any time. To take back your permission, you must send your **written** request to:

Sherry Willis, PhD
Seattle Longitudinal Study
180 Nickerson St., Suite 206
Seattle, WA 98109

If you take back your permission, the research team may still keep and use any patient information about you that they already have. But they can't obtain more health information about you for this research unless it is required by a federal agency that is monitoring the research.

If you take back your permission, you will not need to leave the research study. Changing your mind will not affect any other treatment, payment, enrollment in health plans or eligibility for benefits.

F. Giving permission

You give your permission to release your information by signing this form.

Printed Name of Research Subject Birthdate

Signature of Research Subject Date of signature

You will receive a copy of this signed form. Please keep it with your personal records.