Instructions for Completing the Stand Alone Authorization to Release Protected Health Information for Research Purposes

This form in required to be used in conjunction with the Informed Consent. The informed consent and this authorization will be stamped with the IRB approval and only the original stamped approved originals can be used to make copies for patient enrollment.

1. **Download** form to your computer.

2. Click on box by **Title** and type protocol title.

3. Click on box by **Principal Investigator** and type Principal Investigator name.

4. Click on box by **Sponsor's Name** and type sponsor's name. If no sponsor type "none".

5. Under section **"What PHI will be collected for this study"**
   - Double click box by each item you will use. After double clicking, under Default Value choose 'Checked" then click 'OK'.

6. Under section **"What other information will be collected for this study?"**
   - Using bullet points list all other information you will collect (e.g. lab results, results from x-rays).

7. Under section **"Who will collect the information"**
   - This section is acceptable as written however you may change it to individually list all research staff.

8. Under section **"Who else will see the information at this hospital or office"**
   - If this project is being conducted out of a private practice group or Emory faculty person please click on the check box indicated and add the name of the practice in the fill box.
   - If this project is a multi-center study please check the box 'IRB's at other places where this study will be done'.
   - The 1st, 2nd, and 5th boxes are required to be checked. Do not alter.
   - If the study is an industry sponsored investigational drug or device study check the 6th box indicating that the FDA can look at records.

9. Under section **"Other people outside of this hospital or office that may see the information"**
   - Using bullet points list each of the groups that information will be disclosed to. For example:
     - *Type name of sponsor,* the sponsor of this study who is responsible for collecting results and findings from all the researchers.
     - *Type name of CRO,* the contract research organization whose job is to review and correct any mistakes before the results are given to the sponsor.
     - *Type name of lab,* the laboratory where blood or urine samples are sent for testing.
     - *Type name of place,* where other blood, urine or tissue samples are sent just for research testing or purposes.
     - *Type name or place,* where other people are who are also conducting this research study.

Revised by Children's IRB Office: June 9, 2005

- *Type name of person or place,* where the research results or findings will be analyzed.

If no information will be shared or disclosed outside this hospital or office please indicate by stating the following:

- No information will be shared outside of this hospital or office.

10. You must complete the **expiration blank**.

11. **Print** patient name.

12. **Print name** of parent or legal guardian and use check box to indicate relationship to patient.

13. **Obtain signature** of parent or legal guardian and date of signature.

14. **Print name** of person obtaining authorization.

15. **Person obtaining authorization** must sign and date.

DO NOT CHANGE ANY LANGUAGE IN THIS AUTHORIZATION.

Revised by Children's IRB Office: June 9, 2005