Medical College of Wisconsin Advanced Ocular Imaging Program (AOIP) Authorization for Disclosure of Protected Health Information

WHO WILL SEE MY HEALTH INFORMATION?

By signing this form, you authorize information be released to the Medical College of Wisconsin (MCW) Advanced Ocular Imaging Program (AOIP).

The only MCW employees allowed to handle your health information are those on the study team, those on the Institutional Review Board (IRB), and those who check on the research activities to make sure the hospital's rules are followed.

PURPOSE OF DISCLOSURE

- To determine whether you are eligible to participate in the study
- To allow a member of the study team to call you to discuss your interest in participation and, if necessary, schedule an initial visit (*Note: allowing the staff to contact you in no way obligates you to enroll in the study*)

TYPE OF HEALTH INFORMATION TO BE DISCLOSED

- Demographic information (including your name, date of birth, address, and/or phone number)
- History and diagnosis of eye disease or condition
- Information regarding management and treatment of your eye disease or condition
- The results of any relevant genetic testing conducted for clinical and/or research purposes

AUTHORIZATION IS EFFECTIVE UNTIL

This authorization is effective for 1 year from date of signature and includes records that are created after the date this authorization is signed, up until the expiration date.

IMPORTANT INFORMATION

The following information is important for you to understand:

- The information to be disclosed may include information regarding genetic testing results.
- You have the right to inspect and/or receive a copy of the health information to be released. You may be charged a fee for any copies of records that you receive.
- A photocopy or fax of this authorization shall be considered as valid as the original.
- If you decide not to enroll in the study, study staff will destroy any health information sent to them by your referring doctor.

CAN I REMOVE MY HEALTH INFORMATION ONCE IT IS SENT TO MCW/AOIP?

You have the right to revoke this authorization at any time. The revocation will not apply to information that has already been released. If you revoke this authorization, you must do so in writing to Dr. Carroll at:

Joseph Carroll, PhD
Advanced Ocular Imaging Program
Department of Ophthalmology & Visual Sciences
925 North 87th Street
Milwaukee, Wisconsin 53226 USA

Authorization for Disclosure of Protected Health Information

By signing my name below, I confirm the following:

- I have read (or had read to me) this entire document. All of my questions have been answered to my satisfaction.
- I agree to disclose my health information, including genetic testing results.
- At any time, I can ask the study team to delete/destroy all my health information and genetic results, if it is still identified as mine.

IMPORTANT: You will receive a signed and dated copy of this form. Please keep it where you can find it easily. It will help you remember what we discussed today.

Patient's Name (or name of Parent/Guardian if patient is a minor) ***please print***	**Patient's Signature** (or signature of Parent/Guardian if patient is a minor)	**Date**
Name of Witness (if applicable**)** *please print* (if blind or illiterate patient)	**Signature of Witness**	**Date**

Name of person discussing and obtaining authorization *please print*	**Signature of person discussing and obtaining authorization**	**Date**

THIS SECTION TO BE FILLED OUT BY AOIP STAFF ONLY

Referral PRO: _____

Date Received (MM/DD/YYYY): _____

Received By: _____
