**Revised – August 09, 2022**

Patient name:

DOB:

MRN:

Physician:

# **HIPAA Authorization for Use and Disclosure of Health Information and/or Payment Related Information for Reimbursement Purposes**

## Leave title as is.

**Study Title:** *(insert title of study)*

**Principal Investigator: *(insert name of Principal Investigator)***

**“You”** refers to the study participant. ***(include only if adult study)***

**“You”** refers to you and your child. ***(include only if pediatric study)***

**“We”** refers toSpectrum Healthand Greenphire

This form describes the way that Spectrum Health can share your information with Greenphire, a technology company that specializes in managing compensation and reimbursement to people participating in clinical trials. The information we are asking to collect, use, and share is called Protected Health Information (PHI). PHI is protected by a federal law called the Health Insurance Portability and Accountability Act (HIPAA). In general, we cannot use or share your health information for reimbursement purposes without your permission.

## **Why am I being asked to sign this form?**

You have been asked to participate in a research study that utilizes Greenphire. If you sign this Authorization Form, you agree to the use and disclosure (release) of your health and/or payment related information for purposes of reimbursement associated with the research study, as described in this Authorization Form. Your information will be used to register you with Greenphire so that you can receive a ClinCard which will contain your research study participation reimbursement.

## **What information will be collected and used?**

Your information may be ***accessed (used***) for reimbursement purposes by Spectrum Health and Greenphire. To collect the necessary information, study staff may ask you for the information and/or ask you to complete a W-9 form where appropriate.

The following information about you will be ***collected and disclosed*** for reimbursement purposes in connection with this research study:

* Name
* Phone / Cell Number
* Email
* Address
* Social Security number (Not applicable if providing payments to minors only (i.e., <18years old)

The information listed above that we collect will be ***disclosed (shared)*** to the following organization: **Greenphire.**

The people who see your health and/or payment related information for this reimbursement purpose might not be required to follow HIPAA. It is also possible that anyone who receives your information may re-release it. Because some of these individuals who receive your information for this study may not be required by law to keep your information confidential, we cannot guarantee that your information will not be released or made available to another party once it leaves Spectrum Health. Therefore, we will share your information only if necessary for the reimbursement and we use all reasonable efforts to request that those individuals who receive your information take steps to protect your privacy.

## **How long will my information be used?**

This authorization will remain valid so long as you are taking part in the research study or until you revoke your authorization. If you stop your study participation early, you will receive reimbursement only for those visits and/or tasks you completed.

## **Can I stop my Information from being collected and disclosed?**

Yes, you may change your mind and revoke (take back) this authorization at any time. Even if you revoke this authorization Greenphiremay still use or disclose health information they already have obtained about you as necessary for reimbursement.

To revoke this authorization, you must write or email ***(list investigator’s name and address and email)****.*

You may also write to the Spectrum Health Privacy Department at [privacy@spectrumhealth.org](mailto:privacy@spectrumhealth.org) to revoke this authorization.

## **What happens if I do not want you to collect and/or release my information?**

If you decide not to authorize the collection and release of your information, you will not receive reimbursement via ClinCard for your participation in this research study. Your decision will in no way affect your medical care or cause you to lose any health benefits to which you are entitled.

**Signature(s):**

***\*\*\*\*INFORMATION REGARDING SIGNATURE PAGE\*\*\*\****

***There are five signature block examples attached to this template consent. Adapt the signature page for your study based on the study population. Delete the signature blocks that are not applicable.***

***For example: Omit the signature block regarding children (i.e. do not include parent/guardian signature line(s)) if you do not plan to enroll children in the study.***

**Signature Block for Capable Adult: Long Form**

|  |  |  |
| --- | --- | --- |
| Your signature below documents your permission to take part in this research and to the use and disclosure of your protected health information. You will receive a signed copy of this completed form. | | |
|  |  |  |
| Signature of participant |  | Date |
|  |  | |
| Printed name of participant |
|  |  |  |
| Signature of person obtaining consent |  | Date |
|  |  |  |
| Printed name of person obtaining consent |  |  |

***The following signature block is to be used when an impartial witness is needed for non-readers or visually impaired participants.***

|  |  |  |
| --- | --- | --- |
| I witnessed the entire consent discussion and attest that the information in the consent document and any other written information were accurately read to the participant. I witnessed that all of the participant’s questions were addressed.  I witnessed the participant freely giving consent to take part in this study. | | |
|  |  |  |
| Signature of Impartial Witness |  | Date |
|  |  | |
| Printed name of Impartial Witness |

***The following signature block is to be used when an adult participant is unable to sign their name and date the informed consent form. A witness is required to verify that the participant provided their “mark”.***

|  |  |  |
| --- | --- | --- |
| I witnessed the participant providing their “mark” on the above signature line and have identified the participant by documenting his/her name on the above “Printed name of participant” line. | | |
|  |  |  |
| Signature of Impartial Witness |  | Date |
|  |  | |

Printed name of Impartial Witness

**Signature Block for Adult Unable to Consent**

|  |  |  |
| --- | --- | --- |
| Your signature below documents your permission for the participant named below to take part in this research and to the use and disclosure of this person’s protected health information. You will receive a signed copy of this completed form. | | |
|  |  |  |
| Printed name of participant |  |  |
|  |  |  |
| Signature of legally authorized representative |  | Date |
|  |  |  |
| Printed name of legally authorized representative |  | Relationship to participant |
|  |  |  |
| Signature of person obtaining consent |  | Date |
|  |  |  |
| Printed name of person obtaining consent |  |  |

***The following signature block will be completed if an impartial witness is required for LAR that is a non-reader.***

|  |  |  |
| --- | --- | --- |
| I witnessed the entire consent discussion and attest that the information in the consent document and any other written information were accurately read to the participant.  I witnessed that all of the participant’s questions were addressed. I witnessed the participant freely giving consent to take part in this study. | | |
|  |  |  |
| Signature of Impartial Witness |  | Date |
|  |  | |
| Printed name of Impartial Witness |

**Signature Block for Children**

|  |  |  |
| --- | --- | --- |
| Your signature below documents your permission for the child named below to take part in this research and to the use and disclosure of this child’s protected health information. You will receive a signed copy of this complete form. | | |
|  |  | |
| Printed name of child |
|  |  |  |
| Signature of parent or guardian |  | Date |
|  | * Parent * Guardian (See note below) | |
| Printed name of parent or guardian |
| **Note on permission by guardians:** An individual may provide permission for a child only if that individual can provide a written document indicating that he or she is legally authorized to consent to the child’s general medical care. Attach the documentation to the signed document. | | |

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Signature of person obtaining consent |  | Date |
|  |  |  |
| Printed name of person obtaining consent |  |  |

**Signature Block for Limited English Speaking: Short Form**

|  |  |  |
| --- | --- | --- |
| This English version of the Informed Consent Form is to accompany the Short Form you sign in your stated primary language. You will receive a signed copy of this complete English Informed Consent Form and Short Form together. | | |
|  |  | |
| Printed name of participant |
|  |  |  |
| Signature of person obtaining consent |  | Date |
|  |  |  |
| Printed name of person obtaining consent |  |  |

|  |  |  |
| --- | --- | --- |
| I declare that, to the best of my ability, I have accurately interpreted to/from the participant’s (study subject’s) stated primary language everything said during the informed consent discussion. | | |
|  |  |  |
| Signature of Appointed Medical Interpreter |  | Date |
|  |  |  |

Printed name of Appointed Medical Interpreter Time

|  |  |  |
| --- | --- | --- |
| I declare that I was present for the entire informed consent discussion and that, to the best of my ability, everything said during the discussion was accurately interpreted by the Spectrum Health-appointed interpreter to/from participant’s (study subject’s) stated primary language. | | |
|  |  |  |
| Signature of Witness to Informed Consent Interpretation |  | Date |
|  |  |  |
| Printed name of Witness to Informed Consent Interpretation |  | Time |