CHEROKEE NATION
AUTHORIZATION TO ACCESS, USE OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI) THAT IDENTIFIES YOU FOR A RESEARCH STUDY

An informed consent document for research participation may also be required.
A separate authorization is required for research involving psychotherapy notes.

Title of Research Project:

Leader of Research Team:

Address:

Phone Number:

Purpose of Research Project:

Individuals/Organizations Involved in this Research Project: (Insert ALL names or other identification, or ALL classes, of persons who will have access through CNHS to the PHI for this research project (e.g. research collaborators, sponsors, and others who will have access to the data that includes PHI)

(***NOTE: if the research project is conducted by another entity other than Cherokee Nation, the authorization need only list the name or other identification of the outside researcher (or class of researchers) and any other entity to whom CNHS is expected to make disclosure***)

The PHI that we may use or disclose for this research project includes: (Provide a description of information to be used or disclosed for this research project. This may include, for example, results of physical examinations, medical history, lab tests, or certain health information indicating or relating to a particular disease or condition)

Research Repository: ☐ Includes a Repository ☐ Does not include a Repository

Purpose of Research Repository:

Research Repository: A research repository (data bank) will be used for this research project. Researchers will collect PHI, which may include identifiable tissue specimens, from the participants' health record and store the collected information in an electronic research repository (data bank). The researchers involved in this research project will have access to this repository as authorized by Cherokee Nation Health Services. PHI stored in this research repository will ONLY be used for this research project. Any use or disclosure unrelated to this research project requires your written authorization.

I understand by participating in this research project, that Cherokee Nation researchers may use a research repository to use, maintain, or share my identifying PHI for the purpose of this research project.

I understand that by voluntarily signing this authorization:

I have the right to receive a copy of this authorization.

I understand that my health information will be used or disclosed when required by applicable law.

I understand that my health information may be shared with a public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, and conducting public health surveillance, investigations, or interventions.

I understand that signing this authorization will not affect my eligibility for benefits, treatment, enrollment, or payment of claims related to this research project.

I understand that my health information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipients listed above and no longer protected by the Privacy Regulation.

I have the right to review my health record at any time. However, I understand that I will not be able to obtain and/or review any research project related records until the project is completed.

I understand that I cannot restrict information that may have already been shared based on this authorization.

I understand that no publication or public presentation about the research described above will reveal my identity, unless I sign another authorization.

I understand that if all information that has been de-identified (does or can identify me is removed) from my health information, the remaining de-identified information will no longer be subject to this authorization and may be used or disclosed for other purposes. The information will be de-identified in accordance with the Privacy Rules prior to any information being used or disclosed for other purposes.

I understand that my protected health information may indicate that I have a communicable and/or non-communicable disease which may include, but not limited to diseases such as hepatitis, syphilis, gonorrhea or HIV or AIDS and/or may indicate that I have or have been treated for psychological or psychiatric condition or substance abuse.

The federal rule (42 CFR Part 2) prohibits any further disclosure of information that identifies a patient or participant as having or having had a substance abuse disorder either directly or indirectly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2.

I have the right to withdraw my permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be in writing to ***Cherokee Nation Institutional Review Board, 1325 E. Boone, Tahlequah, OK 74464***, and will not affect information that may have already been shared based on this authorization.

I understand that even if I revoke this authorization, Cherokee Nation and the research team listed above may still use or disclose health information they have already obtained about me as necessary to maintain the integrity or reliability of this research project.

Unless revoked in writing or otherwise indicated, this authorization will expire at the end of the research project. I understand that if I revoke this authorization, I may no longer be allowed to participate in the research described in this authorization.

I understand that I may change this authorization at any time by writing to ***Cherokee Nation Institutional Review Board.***

For questions regarding this research project, please contact:

Cherokee Nation Institutional Review Board
1325 E. Boone, Tahlequah, OK 74464
918-453-5602

Cherokee Nation Health Services
Attn: Health Privacy and Compliance Office
19600 East Ross Street
Tahlequah, OK 74464

I have read this form describing how my PHI will be accessed, used, or shared. I have been able to ask questions and all my questions have been answered to my satisfaction. By signing below, I authorize Cherokee Nation and the research team associated with this research project listed above, to access, use or disclose my PHI for this research project.

Patient/Participant Name:_____

_____ _____
Signature of Patient/Participant Date

_____ _____
Signature of Legal Representative** Date

_____
Print Name of Legal Representative

**If signed by a Legal Representative of the Patient/Participant, provide a description of the relationship to the Patient/Participant and the authority to act as Legal Representative:

_____

Cherokee Nation may ask you to produce evidence of your legal authority to act as the Patient/Participant's legal representative.

A signed copy of this form must be given to the Patient-Participant or the Legal Representative at the time this form is provided to the researcher or his representative.