National Jewish Health
Science Transforming Life

AUTHORIZATION TO BE CONTACTED ABOUT RESEARCH OPPORTUNITIES

Full Name: _____ Date of Birth: _____
(Child/dependent's name if applicable)

Previous Name(s): _____

Address: _____

Contact Telephone: _____ Email: _____

What is the purpose of this Authorization? If we find a research study that might be a good fit, we'd like to contact you and let you know about the study. You are under no obligation to participate in any study we contact you about. We may or may not find a study that would be a good fit. We might also contact you to make sure we have your most current contact information. Signing this form will in no way affect any treatment relationship or payment arrangement you have with National Jewish Health ("NJH").

What health information may be accessed and used for recruitment? NJH researchers and NJH research staff may view and copy any information in your NJH medical or research record to evaluate your eligibility for a particular research study. Under rare circumstances they may access and use sensitive information about you, such as psychiatric or behavioral health care, alcohol or drug abuse, and infectious diseases such as human immunodeficiency disease (HIV), acquired immunodeficiency disease syndrome (AIDS), and hepatitis. Your identifiable health information will not be disclosed outside NJH.

How will NJH use this form? Your willingness to be contacted will be recorded in a NJH database used by researchers for recruiting purposes.

Expiration & Cancellation. This Authorization **expires five years** from the signature date. NJH Researchers and NJH research staff may access and use your information to contact you unless you cancel this Authorization from the database, a child participant turns 18, or this permission expires, whichever happens first. *You may cancel this Authorization at any time* but you must do so in writing. Please send your cancellation to: Privacy Officer, National Jewish Health, 1400 Jackson Street, M113, Denver, CO 80206. If you do cancel, any information collected and copied for a particular study prior to the date of cancellation may still be used to contact you.

Who do I call if I have questions or problems? For questions about your rights as someone who has signed this Authorization, please call the HIPAA Privacy Officer at (800) 414-5939 or 303-270-2610.

I have read this HIPAA authorization form (or it was read to me). I know that signing is voluntary. I can obtain a copy of this form after it is signed.

_____ _____
Signature Date

If applicable:

_____ _____ _____
Signature of Parent or Legal Guardian Date Printed Name of Parent or Legal Guardian

Relationship to Child/Dependent: _____

HIPAA Patient Request _CC

Form may be returned as directed or to: Health Information Management, National Jewish Health, 1400 Jackson Street, L08, Denver, CO 80206-2761