NJH Medical Record Number:_____
(to be completed by NJH staff)

Patient Name:_____Date of Birth: _____

What is the purpose of this form? For more than 100 years, National Jewish Health has been committed to finding new treatments and cures for diseases. As part of our mission, our institution offers both clinical and research opportunities to patients. Participation in clinical research is voluntary, and *this form allows individuals to proactively indicate that they do not want to be contacted about clinical research or 'Opt Out.'* Signing this form will in no way affect any treatment relationship or payment arrangement you have with National Jewish Health ("NJH").

How will NJH use this form? Your decision will be recorded in your NJH Electronic Medical Record. NJH researchers and research staff will not evaluate your eligibility for research studies or contact you for research recruitment.

Cancellation. Please note that if in the future, you change your mind and/or become interested in a particular study, this form will have no bearing on your ability to screen for and potentially enroll in a clinical research trial of your choosing. In addition, you have the right to opt back in at any time by submitting a request in writing to the NJH Health Information Management (HIM) department.

Clinical care. If during the course of your clinical care, your clinician feels that it is critical for you to consider a research trial as a treatment option, this form does not negate the ethical/medical obligation of their bringing the trial to your attention for consideration. You always reserve the right to say no.

Who do I call if I have questions or problems? For questions about your rights as someone who has signed this form, please contact the Privacy Officer at 303-398-1446 or 877-CALL-NJH (877-225.5654) ext.1466.

I have read this Opt-Out form (or it was read to me). I know that signing it is voluntary, and that I may obtain a copy after it is signed.

_____ _____ _____
Patient or Authorized Representative Date Time

If signed by Authorized Representative:
Printed Name: _____
State how Authorized: □ Legal Guardian □ Medical Durable Power of Attorney □ Parent of Minor
□ Power of Attorney □ Proxy Decision Maker □ Other: _____

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HIPAA Patient Request _CC

Patient
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