[**Place on the referring physician's letterhead or on UPMC letterhead and signed copy must be placed in patient's medical records**]

Written Permission to Share Contact Information with Researcher

Dear Patient,

My staff and I frequently work closely with researchers from UPMC and the University of Pittsburgh to help identify patients who may be eligible to participate in various types of research studies. An investigator at [name of institution: e.g., Pitt, UPMC; Graduate School of Public Health; School of Health Related Professions, etc.], Dr. [name of investigator] is conducting a study on [briefly describe study]. My staff or I have provided you with a very brief description of this study and you have expressed a willingness to allow us to share your contact information and some very basic health information about you (primarily your medical condition) with that investigator's research team.

Before we can do so, however, the HIPAA Privacy Rule requires us to obtain your authorization, in writing. Thus, if you are still willing to allow us to share contact information with the researcher, we would like you to sign the authorization below. This will permit a member of the research team to contact you and provide you with more information about the study.

I agree to permit my doctor's health care staff to share the following information with Dr. [name of investigator] who is conducting a study titled [name of study]. This is what will be transmitted to the investigator:

- My contact information (name, address, telephone number, best time to call) so that a member of the investigator's research team can contact me
- My medical diagnosis (which suggests I might be eligible to participate in the study).

I am not obligated to participate in the study, and in fact, I am not obligated to sign this authorization form. If I change my mind after I sign the form, I can send a note to the investigator at [investigator's address] and my contact and health information will be destroyed immediately. Whether I do, or do not, sign will not affect my treatment in your clinic, nor will it affect my current or future relationship with my health care providers, UPMC, or the University of Pittsburgh.

Information about me will be kept as confidential as possible, and it will be shared only once, with this group of researchers. No additional information about me will be shared (that is, this authorization will expire immediately after the information is shared).

I therefore agree to allow you to share my information with the researcher.

Name: _____

Signature: _____ Date/Time: _____

Address: _____

Phone: _____

Best time to call: _____