AUTHORIZATION TO CONTACT HEALTH CARE PROVIDERS

1. Purpose. As a research participant in the Minnesota Educators' Study, I authorize Dr. Susan Gerberich and her research staff to contact the health care providers listed below to request them to complete the attached survey about my previous treatment. I understand the providers will only be asked to complete a survey which includes my name and birth date, and requests information on *work-related assault injuries between* January 1, 2004 and January 1, 2006, with the requested information limited to the type(s) of injury, the body part(s) involved and the beginning and ending dates of treatment, and that no other health information will be either requested or disclosed.

2. Parties Who May Disclose My Individual Health Information. The researcher and the researcher's staff may obtain my individual health information from:

Name of Provider/Clinic: _____
Type of Facility/Agency: (Emergency Department, Urgent Care, Occupational Health Department, Hospital, Family Practice Clinic, etc.) *(Please circle or write in your answer.)* _____
Address: _____
City: _____ State: _____ Zip Code: _____
Type of Provider: (Physician, Chiropractor, Psychiatrist/Psychologist/Therapist, Nurse/Nurse Practitioner/Nurse Clinician, Physician's Assistant, Dentist, Physical or Occupational Therapist, etc.) *(Please circle or write in your answer.)*
_____
Telephone: (____) _____

3. Right to Refuse to Sign this Authorization. I do not have to sign this Authorization. However, my decision not to sign this authorization will not affect any other treatment, payment, or enrollment in health plans or eligibility for benefits.

4. Right to Revoke. I can change my mind and withdraw this authorization at any time by sending a written notice to Dr. Susan Gerberich (Address: School of Public Health, 420 Delaware St. SE, MMC 807, Minneapolis, MN 55455) to inform the researcher of my decision. If I withdraw this authorization, the researcher may only use the protected health information already collected for this research study. No further health information about me will be collected by or disclosed to the researcher for this study.

5. Potential for Re-disclosure. I understand that once my health information is disclosed to the research team it is no longer covered under the HIPAA Privacy Rule. The health care provider(s) who disclosed it can not guarantee that it will not be re-disclosed outside this study. However, the research team and the University of Minnesota's Institutional Review Board (the committee that reviews studies to ensure that the rights and safety of study participants are protected) will take special care to protect my privacy and limit the disclosure of information that could identify me.

This authorization does not have an expiration date.

Please continue to other side →

I have read this information, and am able to keep a copy of this authorization form after it is signed.

_____ _____

Please sign here Today's Date

_____ _____

Please print your name here Birth Date

_____

(Please list any other names you may have used under which your medical records may be filed, i.e. maiden name, nick name, etc.)

Please return this form in the enclosed stamped envelope by February 8, 2007.

Thank you for your participation with the Minnesota Educators' Study!

Please continue to other side →