INFORMED CONSENT TO TAKE PART IN RESEARCH

Consent Version Jan 2019

This consent is appropriate for studies involving questionnaires/surveys and medical records review. If the study only involves medical records review - you may seek waiver of consent. If the study only involves questionnaires or surveys – use the interviews and focus groups template from the CPHS website. Delete these instructions and replace all text in blue with study specific information before submitting to CPHS.

**Study Title:** <Add your study title here>

**Study Sponsor:**  <Delete this line if your study is not sponsored>

**Principal Investigator:** <PI Name, degree, short title>

**Study Contact:** < XXX-XXX-XXXX. If study contact person is different from PI, write the name of study contact here>

You are being invited to be in this research study because you have <xxx>. Please feel free to ask questions at any time. Your participation is voluntary and you can stop at any time without penalty.We are doing this research study to learn more <briefly outline purpose of the study>.

If you agree to participate in this study:

* We will collect information from your medical records. We will collect information about your <list information which will be taken from the medical records>.
* We will ask you to fill out a questionnaire about <xxx>. It will take about <time> to answer the questions. You do not have to answer any questions that you do not wish to answer.

We will only keep information that could identify you long enough to match your responses with your medical records. Your privacy is very important to us. We will make every effort to protect the information we collect. In addition to the study team, other UTHealth employees may look your research and medical records and will see personal information about you. We will take steps to keep the data confidential, but there is a small risk that your information could be accidentally disclosed to people not connected to the research.

If you sign this document, you give permission to UTHealth, Memorial Hermann Healthcare System, or Harris Health System to use and disclose (release) your health information. The health information that we may use or disclose for this research includes <Provide a description of information to be used or disclosed for the research project. This may include, for example, all information in a medical record, results of physical examinations, medical history, lab tests, or certain health information indicating or relating to a particular condition>. Please understand that health information used and disclosed may include information relating to HIV infection, drug abuse, alcohol abuse, behavioral health, and psychiatric care.

Use for Investigator Initiated Studies:

Personal identifiers such as your name and medical record number will be removed from the information and samples collected in this study. After we remove all identifiers, the information or samples may be used for future research or shared with other researchers without your additional informed consent.

People who receive your health information may not be required by Federal privacy laws (such as the Privacy Rule) to protect your health information and may share your information with others without your permission, if permitted by laws governing them. You will not be personally identified in any reports or publications that may result from this study. If all information that does or can identify you is removed from your health information, the remaining information will no longer be subject to this authorization and may be used or disclosed for other purposes.

Please note that you do not have to sign this Authorization, but if you do not, you may not participate in this research study. UTHealth and Memorial Hermann Health System or Harris Health System may not withhold treatment or refuse treating you if you do not sign this Authorization.

You may change your mind and revoke (take back) this Authorization at any time. Even if you revoke this Authorization, researchers may still use or disclose health information they already have obtained about you as necessary to maintain the integrity or reliability of the current research. To revoke this Authorization, you must contact <PI Name> in writing at <PI campus mailing address>.

This Authorization will expire 6 years after the end of the study.

If you have any questions about your participation in this research, you can call the Institutional Review Board (IRB) at 713-500-7943. The IRB is a committee that has reviewed and approved this research study (HSC-XX-XX-XXXX).

**SIGNATURES**

Sign below only if you understand the information given to you about the research and you choose to take part in this research study. Make sure that all your questions have been answered. If you decide to take part in this research study, a copy of this signed consent form will be given to you.

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| Printed Name of Subject |  | Signature of Subject |  | Date |
|  |  |  |  |  |
| Printed Name of Legally Authorized Representative |  | Signature of Legally Authorized Representative |  | Date |
| Printed Name of Person Obtaining Informed Consent |  | Signature of Person Obtaining Informed Consent |  | Date |