CONSENT TO DISCLOSE HEALTH/REGISTRATION INFORMATION

This form documents and individual’s consent to disclose personally identifying health or registration information in compliance with Section 34 of the *Health Information Act*. It is to be completed in full by the subject before the disclosure, presented to the custodian, and filed as part of the subject’s records.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize *insert name of Custodian of health information* to disclose the following individually identifying health information (*state specific information required*) to insert n*ame of Study Doctor and/or his research associates* in order to *state purpose:*

I agree to release this information for the purposes of the *state full research project title* and understand that no individually identifying health information will be used in the study database or in publication.

I understand why this health information is needed and the risks and benefits to me of consenting or refusing to consent to allow the disclosure of this information. I also understand that I may revoke this consent any time.

This consent is effective today, as per my dated signature below, and continues until my participation in the study ends.

Subject’s Name Witness Name

Subject’s Signature Witness Signature

Date Date