Bar Code

UF Institutional Review Board
UNIVERSITY of FLORIDA

Bar Code

MRN:_____ Patient Name: _____ Visit Date: _____

INFORMED CONSENT FORM
to Participate in Research, and

AUTHORIZATION
to Collect, Use, and Disclose Protected Health Information (PHI)

Under the name "**Consent2Share**", the University of Florida and Shands Teaching Hospital & Clinics Inc. (UF Health) are asking for your permission to include you in this Research Contact Registry. If you sign this document, you will agree to:

a) Periodic review of your medical information to see if you might qualify for a future research study, and if so,
b) Be contacted sometime in the future about being part of new research studies at UF Health.

Please read the information below before you decide if you want to participate in this Research Contact Registry. If after you read this, you still have questions, do not sign this form until you talk to your physician or call the Consent2Share Helpline at (352) 265-3282.

The choice to let UF Health review your medical information and contact you later to see if you are interested in joining a future research study is entirely up to you. If you chose not to participate in the registry you will not be penalized or lose any benefits that you would otherwise be entitled to.

If you decide to participate in this research contact registry:

- Your medical record will be flagged as someone who is interested in hearing about research opportunities
- Your name and contact information will be shared with researchers once the researcher has an approved study and your records show that you potentially qualify for the study. Studies are approved by the Institutional Review Board (IRB), which is a committee of scientists, ethicists and community members.
- If you are contacted, you will be told about a specific research study at that time. At that time, you can choose whether or not to be involved in that research project.

Other things you should know:

- Your medical information will be kept in a very safe location (on a password-protected and encrypted computer server).

- If you do not agree, you will not be denied or refused any treatment, payment or enrollment in a health plan, or lose any benefits that you would otherwise be entitled.
- There will be no cost to you for your involvement in this registry.
- Your involvement in this registry might not result in any benefit to you.
- There may be other research studies that involve the review of your medical information, any of which you can choose to participate in.
- You may choose to stop your involvement at any time. You will not be penalized or lose any benefits to which you are otherwise entitled. You can call the Consent2Share Helpline at (352) 265-3282 to have your name removed from the "re-contact" list.
- By signing this document, UF Health will be allowed to collect, use and/or give out your contact and medical information, but only to other researchers whose research is approved by an IRB.

What are the Risks to Agreeing to be in this Research Contact Registry?

- That your medical data being reviewed by a researcher is given to people that should not have it. Every effort will be made to keep your information secure and confidential. However, there is a small risk that an unauthorized person may see your information. Depending on the information this could affect you and/or your family (for example: embarrass you, cause you anxiety or distress).
- You may be contacted several times for different research studies. If at any time you wish to be taken off the "re-contact registry", you may contact the Consent2Share Helpline at (352) 265-3282.

Signature of Subject providing Informed Consent & HIPAA Authorization

You have been informed about the possible review of your medical information and possible re-contact if you are a potential candidate for a research study. You have also been told of possible benefits and risks, and that you are free not to agree to be in this Research Contact Registry. You have received a copy of this informed consent or have been told where a copy this informed consent is located on a web site. You have been given the opportunity to contact your physician or the Helpline to ask questions before you sign, and you are aware that you can ask other questions at any time.

Please Choose:

If you potentially qualify for a future research study, you agree **to be contacted** about your potential involvement in a research study. These studies will be described to you and you can choose whether or not to participate at that time.

(Please **check** Yes or No, then **sign** below) _____YES _____NO

_____ _____
Signature of Person Consenting and Authorizing Date

_____
Print Name of Person Consenting and Authorizing