

## WRITTEN PERMISSION TO SHARE CONTACT INFORMATION WITH INVESTIGATOR

Dear Parent/Patient,

My staff and I frequently work closely with research investigators to help identify patients who may be eligible to participate in various types of research studies.

It has come to our attention that the investigator listed below is conducting a study for which you may be eligible.

Investigator Name:

Department:

Institution:

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 your medical condition and contact information with the investigator, 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.

A signed copy of this form will be placed in your Children's Wisconsin medical record.

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I agree to permit Dr. \_\_\_\_\_ or their health care staff at \_\_\_\_\_ to share the following information with Investigator \_\_\_\_\_ at \_\_\_\_\_ who is conducting a study entitled:

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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 this 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 contact the Investigator

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at \_\_\_\_\_ 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 or with Children's Wisconsin.

Information about me will be kept as confidential as possible, and it will be shared only once, with this group of investigators. 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 investigator.

Patient/Parent name: \_\_\_\_\_

Patient/Parent  
signature: \_\_\_\_\_ Date/Time: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Best time to call: \_\_\_\_\_

**INSTRUCTIONS FOR USE:**

Per the Children’s Wisconsin HRPP [guidance on recruitment](#) “Potential subjects who have been identified as possibly qualifying for a research project without their knowledge (via an IRB approved partial HIPAA waiver for screening) must be initially contacted by an individual with a treating relationship to the potential subject. First contact should be made by persons directly involved in prospective participants’ care, rather than unknown researchers. Persons identified through a clinical record review should be contacted via an individual with a treating relationship with the patient.”

There are 2 scenarios for which this form is required:

1. A researcher at another institution would like the contact information/dx of patients who are potentially eligible for their study for purposes of recruitment.
2. A Children’s Wisconsin treating provider wants to pass along the contact information/diagnosis of a patient who may be eligible for the investigator’s study.
  - a. This treating provider is not covered by the partial HIPAA waiver for screening which is attached to the investigator conducting the study.

There are 2 scenarios for which this form does not apply:

1. A CW investigator is recruiting for their own study and wants to access medical records to screen for eligibility. This activity would be covered by the partial HIPAA waiver for screening approved by the IRB for the study.
2. A treating provider at an external institution (including Froedert Hospital/MCW or Versiti) wants to provide contact information/diagnosis to a CW investigator.
  - a. The external institution/provider is responsible for obtaining any required HIPAA authorizations and for following the policy of their institution before providing a potential subject’s information to the CW investigator.

This authorization, when applicable, must be obtained prior to the disclosure of patient contact information and diagnoses by a Children’s Wisconsin provider to an investigator. This requirement applies to all referrals where the investigator does not have an established treatment relationship with the potential subject.

This form should be included in eBridge, section 52 of the PRO, or included with the engagement determination form, if it will potentially be used as part of the recruitment.