Texas Heart® Institute
at St. Luke's Episcopal Hospital
Stem Cell Center

Authorization for Use and Disclosure of Health Information for Research Purposes

We understand that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your special authorization before we may use or disclose your protected health information for the research purposes described below.

Protected health information includes all information about you collected during the research study for research purposes and the information about you in medical records that is related to the research study. The information collected may include your name, date of birth, address, social security number, and results of all the tests and procedures done during the study.

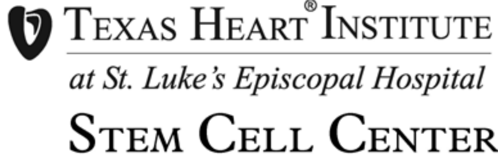
The records used and disclosed pursuant to this authorization form may include information relating to: Human Immunodeficiency Virus ("HIV") infection or Acquired Immunodeficiency Syndrome ("AIDS"); treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care.

If health information about you is required, the reviewers may need your entire medical record.

USE AND DISCLOSURE COVERED BY THIS AUTHORIZATION

Who will disclose, receive, and/or use the information? The following person(s), class(es) of persons, and/or organization(s) may disclose, use, and receive the information, but they may only use and disclose the information to the other parties on the list, to the research subject or his/her personal representative, or as otherwise permitted or required by law.

- Investigator (study doctor), research coordinator, members of the research staff
- Study sponsor [NAME] and any people or companies contracted by the sponsor, which may include data monitoring committees, contract research organizations, and consultants who review study results
- Members of the St. Luke's Episcopal Hospital Institutional Review Board (IRB)
- Members of the hospital's administrative staff who are responsible for administering clinical trials and other research activities
- The United States Food and Drug Administration, Centers for Medicare and Medicaid Services, and other regulatory agencies
  __Others (as described below—if no "others" are listed, delete this line)



The receivers of the information may further disclose your health information. If disclosed by them, the information may no longer be covered by federal or state privacy regulations.

Information collected about you for purposes of this research study may be kept in a research study record separate from your medical records. You will not be able to obtain your research study record until the end of the study.

In order to participate in this research study, you must sign this authorization that gives permission to share your personal health information. However, you cannot be denied medical treatment unrelated to the research study because you did not sign this authorization.

The results of the study may be published in a medical book or journal, or presented at a meeting for education purposes. Neither your name, nor any other personal health information that specifically identifies you, will be used in those materials or presentations.

This permission to share your personal health information for this study does not have an expiration date. If you no longer want to share your personal health information, you may revoke (cancel) your permission at any time by writing to the study staff and/or the study doctor at the address below:

Lynette Westbrook, RN
6770 Bertner Ave MC2-255
Houston, TX 77030
832-355-9405

Even if you revoke your permission, the Researchers may still use and disclose the health information that they have already obtained as necessary to evaluate the study results. If you start the study and then revoke your permission, you will not be able to continue to participate in the study.

SIGNATURE

I have read this form and all of my questions about this form have been answered. I hereby consent to the performance of the above procedures upon me. By signing below I acknowledge that I have read and accept all of the above and have been provided with a copy of this authorization.

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Signature of Subject or Personal Representative

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Print Name of Subject or Personal Representative

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Date