Protocol Title: ____
____

Principal Investigator Name: ____

Version Date: _______________

IRB #: _____________________

Parent or Guardian
Research Authorization Form
University of Wisconsin-Madison

Researchers at the University of Wisconsin-Madison (UW) are required to get written permission from a child's parent or guardian to use the child's health information in a *[research study, registry, tissue bank, or other]*. This permission is called an "Authorization." In order for your child to take part in this *[research study, registry, tissue bank, or other]* you must sign this Authorization form.

A. How will my child's health information be used?

Your child's health information will be used to:

B. What information will be used?

The following information about your child's health will be used for this *[research study, registry, tissue bank, or other]*:

C. Who will use my child's health information?

The people who hold your child's medical records will share health information with the UW researchers, who may also share it with other people outside UW. (If your child's health information will be shared outside UW-Madison, those outside institutions and researchers receiving your child's health information will be listed below.)

1. Record Holders:

2. Researchers and Others:

***D.* How long will the permission last?**

This Authorization does not have an end date. You can end this Authorization at any time, however, by withdrawing your permission in writing. Beginning on the date your permission ends, no new health information from your child will be used. Any health information that was shared before you withdrew your permission will continue to be used. After this Authorization ends, your child can no longer actively take part in this *[research study, registry or tissue bank]*.

Withdrawal of your permission should be made in writing to the person whose name is listed here:

[Principal Investigator's name and address]

E. Is the permission voluntary?

Your permission is voluntary. You do not have to sign this Authorization form and you may refuse to do so. Your child's health care providers must continue to provide your child with health care services even if you refuse to sign this Authorization form. If you refuse to sign this form, however, your child cannot take part in this *[research study, registry, tissue bank, or other]*.

F. How will my child's health information be protected?

Whenever possible your child's health information will be kept confidential. Federal privacy laws, however, may not apply to some people outside of UW who can share your child's health information without your permission. If you signed a consent form for your child to take part in this research, more information about confidentiality protections may be found there.

G. Additional information.

You should take as much time as you need to make your decision about giving permission for the use of your child's health information for this *[research study, registry, tissue bank, or other]*. Please ask any questions you may have about this Authorization form.

Certification: I have read this Authorization form describing how my child's health information will be used. I have had a chance to ask questions about the use of my child's health information and I have received answers to my questions. I agree to the use of my child's health information for this *[research study, registry, tissue bank, or other]*.

Child's name:
(Please print)____

Parent or Guardian Name
Signing Authorization:
(Please print)____

Signature of Parent or Guardian:
____**Date:**_______________

Relationship to Child: ___________________________________
(Please print)

****YOU SHOULD RECEIVE A COPY OF THIS FORM AFTER SIGNING IT****

Signature of person obtaining Authorization:

___________________________________ **Date:** ________________