

**REVOCAION OF AUTHORIZATION FOR USE AND DISCLOSURE OF YOUR HEALTH
INFORMATION FOR RESEARCH**

Return To:

PI Address: _____ PI Phone: _____

OR

Institutional Review Board MedCenter One, Suite 200 501 E. Broadway Louisville, KY 40202

Title of Study: _____

IRB #: _____

To Whom It May Concern:

I would like to discontinue my participation in the research study noted above. I understand that health information already collected will continue to be used as discussed in the Authorization I signed when joining the study.

Your options are (**choose one**):

Withdraw from Study & Discontinue Authorization:

Discontinue my authorization for the future use and disclosure of protected health information. In some instances, the research team may need to use your information even after you discontinue your authorization, for example, to notify you or government agencies of any health or safety concerns that were identified as part of your study participation.

Withdraw from Study, but Continue Authorization:

Allow the research team to continue collecting information from my personal health information. This would be done only as needed to support the goals of the study and would not be used for purposes other than those already described in the research authorization.

I understand that I will receive confirmation of this notice.

Signature of Subject

Date Signed

Signature of Subject Representative (if subject unable to sign)

Date Signed

Printed Name of Subject OR Subject Representative

Birthdate

Address

Phone Number

Optional:

I am ending my participation in this study because:

