

## **FRONTIERS:** Heartland Institute for Clinical and Translational Research Permission for Contact about Future Research Studies

Physicians and other researchers at KU Medical Center (KUMC) conduct research to make new discoveries and promote the health of our patients. We are asking for your permission to contact you if there is a research study for which you, your child or the person for whom you are making decisions might qualify. Only authorized researchers with approved studies may request a list of patients willing to be contacted.

The University of Kansas Physicians, KU Hospital and KU HealthPartners will allow authorized researchers to use information in your records to identify potential study participants. We will use information such as diagnosis codes, dates of medical events or procedures, current medications, age, ethnicity, gender and zip code to determine which studies might be applicable to you or the person for whom you are signing. Authorized researchers will be given only contact information (e.g.,name, e-mail address, mailing address and phone number) of individuals who may qualify for a study, and they will provide you with details about the study. You are free to say yes or no to any study.

The privacy of your health information is covered by the Federal Health Insurance Portability and Accountability Act (HIPAA). While some researchers are not required to follow the HIPAA rules, if they disclose your information, there may be other laws that protect your information from improper use.

Signing this form is completely voluntary. If you do not want to be contacted about research, do not sign this form. Choosing not to sign will have no effect on the care and services you, your child or the person for whom you are signing receives at KUMC.

This form also allows you to receive information via e-mail. There are risks associated with communications via e-mail. For instance, there is a risk that e-mail communications could be intercepted or sent to unintended parties. Our current policy is to send e-mails that contain health information through a secured system. This system will require you to create a new user name and password to access your e-mail on our servers. Our policy may change in the future to allow e-mails that contain health information be sent unsecured, like regular email.

If you want all email to be sent unsecure (if the policy changes), like regular e-mail, initial here: \_\_\_\_\_\_ If you <u>do not</u> want to receive any communications via e-mail, initial here: \_\_\_\_\_\_

Signature of Patient	Print Patient Name	Date
Signature of Parent or Legal Guardian	Print Name of Parent/Guardian and Relationship	Date
E-mail Address	Date of Birth	

You will receive a copy of this signed form. This permission for contact will stay in effect indefinitely, unless you cancel it. To cancel your permission, write to Richard Barohn, MD; Director, Frontiers: The Heartland Institute for Clinical and Translational Research; University of Kansas Medical Center, Mail Stop 6011; 4350 Shawnee Mission Pkwy; Fairway, KS 66205. If you cancel your permission, we will make the change in our records for future reference. If you have any questions about being contacted about research, please call the Frontiers Office at 913-588-6290. If you take the form home for review, make a copy and mail the signed form back to the above address.