MEDICAL RECORD RELEASE AND HIPAA AUTHORIZATION
Release and Use of Protected Health Information

I hereby authorize the release and use of the health information described below, including health information that identifies or could be used to identify myself or my child.

Name of person whose records are to be released:_____

Birth date: _____

Protected Health Information that May be Used/ Released:

_____ Genetics or chromosome report

_____ _____
Name of laboratory or pediatrician phone

_____ Other (please specify):

_____ _____
Name of laboratory or pediatrician phone

Persons/Entities by Whom the Protected Health Information May be Used/to Whom it May be Released:
Dr. Elizabeth Leslie / Grace Carlock (study coordinator)
Department of Human Genetics
Emory University School of Medicine
615 Michael Street
Room 305N
Atlanta, GA 30322
Telephone (404) 727-3505
Fax (404) 727-3949

The privacy of your health information is important to us. In protecting your health information that identifies you, we will follow all requirements of the Health Insurance Portability and Accountability Act ("HIPAA" for short) that apply. This form will let you know how we will use any health information that you give us for this study that identifies you.

Purpose(s) for Which the Protected Health Information May be Released and Used:
We ask your permission to obtain medical records documenting you or your child's craniofacial birth defect. Although we are not requesting the following information, these items may be included with the medical records that we receive: HIV and/or AIDS status, drug dependency including treatment for alcohol or drug abuse, psychiatric information including treatment for psychiatric disorders, and genetic information in addition to that requested.

Expiration Date/Event:
This Authorization will expire at the end of the study.

Re-Disclosure of Protected Health Information
I understand that any Protected Health Information obtained during this study will remain confidential and will be disclosed only with my permission, except as may be required by law. This means that agencies that make rules and policies about how research is done have the right to review these records. There are a number of University persons/units, government agencies and other individuals and organizations that may use and disclose your health information to make sure that the research study is being conducted correctly and safely, and to monitor and regulate the research or public health issues. These people and organizations include the following: the Emory University Institutional Review Board and the Emory University Office of Research Compliance.

Other Items You Should Know:
HIPAA only applies to people or organizations that are health care providers, health care payers or healthcare clearinghouses. HIPAA may not apply to all information users. If HIPAA doesn't apply to an information user, then that user doesn't have to follow HIPAA requirements when it uses or discloses your health information. If your identifying information is removed from your health information, then the information that remains will not be subject to this authorization or covered by HIPAA, and it may be used or disclosed to other persons or organizations, and/or for other purposes.

Revocation of Authorization:
You do not have to sign this authorization. In addition, if you sign this authorization, later, you may change your mind at any time and revoke (take back) this authorization. If you want to revoke this authorization you must write to: Dr. Elizabeth Leslie, Department of Human Genetics, Emory University School of Medicine, 615 Michael Street, Room 305N, Atlanta, GA 30322.

If you revoke your authorization, the researchers will not collect any more health information that identifies you, but they may use or disclose identifiable information that you already gave them in order to notify any of the other information users that you have taken back your authorization; to maintain the integrity or reliability of the research study; and to comply with any law that they are required to obey.

Copy of Form
I will receive a copy of this form for my records.

_____ Date & Time:_____
Signature

_____ _____
Printed Name Relationship to individual with cleft