University of California
Cancellation of Permission to Use Personal Health Information for Research

To Be Completed by Investigator:

Study IRB Number:	
Study Title:	
Name of Principle Investigator:	

A. What is the Purpose of this Form?

By signing this form, you are cancelling your permission for the research team to access your University of California medical records for the purposes of research in the study identified above.

B. What Does Cancellation Mean?

If you cancel your permission, you are revoking the authorization you provided in the *Permission to Use Personal Health Information for Research* form (HIPAA authorization form), and as of the date of receipt of this form, the research team will no longer be allowed to access your University of California medical record for the purposes of the study identified above, unless the law requires it. However, the information already collected for the study may continue to be used as described in the original HIPAA authorization form and/or *Research Informed Consent Form*. The research team will continue to protect your confidentiality as described in the original Consent Form and the original HIPAA authorization form.

You may want to ask someone on the research team if canceling your permission will affect your medical treatment or your participation in the study. This cancellation will not affect your regular medical treatment outside of this research study. Nor will it affect your ability to participate in other research studies. However, as cancellation may impact your ability to continue participation in this study, it is recommended that you consult with the research team to ensure you can be withdrawn from the study safely. It is recommended that you ask someone in the research team whether any safety measures are necessary prior to study withdrawal.

C. Signature

You will be given a signed copy of this form.

Subject's Name (printed):	

To cancel your permission for the research team to access your University of California medical record in the above identified study, please sign below.

____ __________________

Subject's Signature Date

Note: If the subject is a minor, an adult incapable of giving consent, an individual signing with an "X", or is unable to read the authorization, then complete the Special Signatures Section below.

SPECIAL SIGNATURES SECTION

D. **If you agree to cancel permission for the research team to access the subject's University of California medical record in the above identified study, and you are the subject's Legally Authorized Representative (LAR), please print your name and sign below.**

______________________________________	____________________
Legally Authorized Representative's Name (print)	Relationship to the Subject
______________________________________	____________________
Legally Authorized Representative's or Witness Signature	Date

E. **If the subject signed above with an "X" and you witnessed the signing, please print your name and sign below.**

____
Witness to the "X" (print)

______________________________________	____________________
Witness Signature	Date

F. **If the subject or Legally Authorized Representative (LAR) is unable to read the authorization, the translator or reader <u>and</u> a witness sign here:**

I have accurately and completely read this Authorization to ______________________ (subject or LAR's name) in ________________ (language), the subject or LAR's primary language. **The subject or LAR has verbally affirmed his/her Authorization to me and to the witness.**

____
Translator or Reader's Name (print)

______________________________________	________________
Translator or Reader's Signature	Date

____
Witness' Name (print)

______________________________________	________________
Witness' Signature	Date

To Be Completed by Investigator:

Date Cancellation Received:	
Name of Individual Received by:	