St. Vincent Frontier Cancer Center

a St. Vincent Healthcare Facility

AUTHORIZATION TO USE AND DISCLOSE INDIVIDUAL HEALTH INFORMATION FOR RESEARCH PURPOSES

As a patient of St. Vincent Frontier Cancer Center, I understand that I have the opportunity to be screened for opportunities to participate in clinical trials. A clinical trial is a research study conducted with cancer patients, usually to evaluate a new treatment. Each study is designed to answer scientific questions and to find new and better ways to help cancer patients.

In addition to St. Vincent Frontier Cancer Center's internal screening of patients, Montana Cancer Consortium, a legal entity separate and distinct from St. Vincent Frontier Cancer Center, screens St. Vincent Frontier Cancer Center patients and provides St. Vincent Frontier Cancer Center patients with more opportunities to participate in clinical trials.

I understand and am aware of the fact that Montana Cancer Consortium will examine my medical charts to screen me for possible clinical trial opportunities. I understand that medical charts contain protected health information, and I agree and permit Montana Cancer Consortium to have access to this information. By signing this form, I fully authorize Montana Cancer Consortium to examine my medical charts for this purpose.

Please Note: If there are any parts of this form that you do not understand, please be sure to ask us for further clarification.

1. **Purpose.** As a St. Vincent Frontier Cancer Center patient, I authorize Montana Cancer Consortium and its staff to access my individual health information for the purpose of screening me for possible clinical trial opportunities.

2. **Individual Health Information to be Used or Disclosed.** My individual health information that may be used or disclosed to conduct this screening includes: demographics information, results of physical exams, blood tests, x-rays, and other diagnostic and medical procedures as well as medical history and progress notes.

3. **Parties Who May Disclose My Individual Health Information.** Montana Cancer Consortium and its staff may obtain my individual health information from St. Vincent Frontier Cancer Center for the purposes of screening me for possible clinical trial opportunities. I authorize St. Vincent Frontier Cancer Center to disclose my individual health information to Montana Cancer Consortium and its staff for the purposes of screening me for possible clinical trial opportunities.

4. **Parties Who May Receive or Use My Individual Health Information.** The individual health information disclosed by St. Vincent Frontier Cancer Center may be received and used by Montana Cancer Consortium and its staff. My information may also be shared with individuals responsible for general oversight and compliance of these research activities.

5. **Right to Refuse to Sign this Authorization.** I do not have to sign this Authorization. If I decide not to sign the Authorization, my medical chart and file will not be screened by Montana Cancer Consortium. However, my decision not to sign this authorization will not affect any other treatment, payment, or enrollment in health plans or eligibility for benefits.

6. **Right to Revoke.** I can change my mind and withdraw this authorization at any time by sending a written notice to St. Vincent Frontier Cancer Center and to Montana Cancer Consortium to inform them of my decision. If I withdraw my authorization, no additional efforts to collect individually identifiable health information about me will be made. If I withdraw this authorization, Montana Cancer Consortium may only use and disclose the protected health information already collected for the screening. No further health information about me will be collected by or disclosed to Montana Cancer Consortium for screening purposes.

7. **Potential for Re-disclosure.** Once my health information is disclosed under this authorization, there is a potential that it will be re-disclosed outside this screening and no longer covered by this authorization, However, St. Vincent Frontier Cancer Center and Montana Cancer Consortium are careful to protect your privacy and limit the disclosure or identifying information about you.

   7A. Also, there are other laws that may require my individual health information to be disclosed for public purposes. Examples include potential disclosures if required for mandated reporting of abuse or neglect, judicial proceedings, health oversight activities, and public health measures.

This authorization does not have an expiration date.

I am the patient or personal representative authorized to act on behalf of the patient.

I have read this information, and I will receive a copy of this authorization form after it is signed.

This document constitutes a direct request on my part to the entities identified above to provide the protected health information described in this document in accordance with 45 CFR 164.524 *Access of individuals to protected health information, and authorizes the release the recipients identified above to act on my behalf as my personal representative in seeking this information.*

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Signature of patient or patient's personal representative *Date*

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Printed name of patient or patient's personal representative

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Description of personal representative's authority to act on behalf of the patient