**HUMAN RESEARCH AFFAIRS**

**AUTHORIZATION TO RELEASE CONTACT INFORMATION FOR RESEARCH RECRUITMENT**

This Authorization must be used for Mass General Brigham providers to refer patients to other Mass General Brigham providers for the purpose of recruiting them to participate in research conducted at Mass General Brigham.

In the course of clinical treatment or otherwise, providers may discuss research options with their patients and refer them to participate in research. If information, including contact information, about the patient needs to be shared for recruitment purposes between Mass General Brigham providers, this Authorization must be completed. This Authorization must be obtained from the patient prior to sharing patient information with the study team to initiate contact.

This Authorization is not needed if the potential participant is provided with information about the study and they are asked to initiate contact with the study team. This Authorization does not need to be submitted to the IRB, but the recruitment section of the protocol must describe how this Authorization will be used to recruit potential participants.

The signed Authorization should be maintained in the study records to document compliance with recruitment procedures. It is the research team's responsibility to obtain the completed Authorization from the Referring Provider, not the participants.

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| |  |  | | --- | --- | | **A** | **STUDY INFORMATION** | | |
| **MGB IRB Study #** |  |
| **Principal Investigator** (PI) |  |
| **Study Title** |  |
| **Referring Provider** |  |
| **Referring Provider Contact Information** | **Email:**  **Phone:** |

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| |  |  | | --- | --- | | **B** | **RELEASE OF HEALTH INFORMATION** | |
| I, (*Patient’s Full Printed Name)* give my permission for  *(Referring Provider Printed Name)* and staff members of Mass General Brigham working for the Referring Provider to release the following information about me for the purpose of research recruitment:  Name  Preferred Contact Information (Email and/or Phone Number):  This information will be shared with the above-referenced Principal Investigator and their study team.   * I understand and agree that: This Authorization is voluntary, and I do not have to sign it. If I do not sign it, information about me will not be released to the study team for research recruitment for this study. * My treatment, payment, health plan enrollment, or eligibility for benefits will not be affected if I do not sign this Authorization. * I can cancel this Authorization at any time in writing by contacting the Referring Provider at the information above. After canceling my Authorization, I understand that the researchers and the people my information was given to may have already used the information, but my information will not be used by the study team again. * This Authorization will expire one year from the date of signature. * I will be given a copy of this form after I have signed it.   **Name and Signature of Patient**    Patient Name - Printed    Patient Signature Date  **If applicable: Name and Signature of Legal Representative**    Name - Printed    Signature Date  Relationship to Patient-Printed: | |