NYU School of Medicine
NYU LANGONE MEDICAL CENTER

Institutional Review Board
Human Research Protection Program
1 Park Avenue | 6th Floor | New York, NY 10016 http://irb.med.nyu.edu

RESEARCH AUTHORIZATION

Title of research study: NYU Takotsubo Registry **ID Number:**

Patient/Subject Name:

Study#: 09-0746

We understand that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your written authorization before we may use or disclose your protected health information for the research purposes described below. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed. Please read the information below carefully before signing this form. If you have questions about this form you may contact the NYUSOM IRB at 212.263.4116.

USE AND DISCLOSURE COVERED BY THIS AUTHORIZATION

The Principal Investigator or a member of the research team must answer these questions completely before providing this authorization form to you. DO NOT SIGN A BLANK FORM. You or your personal representative should read the descriptions below before signing this form.

Who will disclose, receive, and/or use the information? This form will authorize the following person(s), class (es) of persons, and/or organization(s) to disclose, use, and receive the information:*

- Every research site for this study, including this hospital, and including each sites' research staff, Health and Hospital Corporation research staff of NYU, and medical staff
- The research staff for the International Takotsubo Registry (InterTAK), University Hospital Zurich
- Every health care provider who provides services to you in connection with this study
- Any laboratories and other individuals and organizations that analyze your health information in connection with this study in accordance with the study's protocol
- The United States research regulatory agencies, other foreign regulatory agencies, and others as required by law
- The members and staff of the hospital's affiliated Institutional Review Board
- The members and staff of the hospital's affiliated Privacy Board
- Principal Investigator: Harmony Reynolds, MD
- Study Coordinator(s)
- Members of the Research Team
- The Patient Advocate or Research Ombudsman (CTSI)
- Data Safety Monitoring Board/Clinical Events Committee

* If, during the course of the research, one of the companies or institutions listed above merges with or is purchased by another company or institution, this authorization to use or disclose protected health information in the research will extend to the Successor Company or institution.

What information will be used or disclosed? The appropriate bullets should be included below and the descriptions should be in enough detail so that you (or any organization that must disclose information pursuant to this authorization) can understand what information may be used or disclosed.

- Your medical records
- Images from medical tests, such as echocardiograms, electrocardiograms, angiography, magnetic resonance imaging, computed tomography
- Your research record
- Results of laboratory tests
- Clinical and research observations made during your participation in the research
- Social security number, to allow search of public records for vital status (optional, but appreciated). **Note:** your name, address, email address, telephone number and social security number will NOT be shared with the InterTAK research team.

SPECIFIC UNDERSTANDINGS

By signing this research authorization form, you authorize the use and/or disclosure of your protected health information described above. The purpose for the uses and disclosures you are authorizing is to conduct the research project explained to you during the informed consent process and to ensure that the information relating to that research is available to all parties who may need it for research purposes. Your information may also be used as necessary for your research-related treatment, to collect payment for your research related treatment (when applicable), and to run the business operations of the hospital.

This information may be redisclosed or used for other purposes if a recipient described on this form is not required by law to protect the privacy of the information.

You have a right to refuse to sign this authorization. You may choose to speak to the researcher and/or your own physician regarding medical alternatives to the study. While your health care outside the study, the payment for your health care, and your health care benefits will not be affected if you do not sign this form, you will not be able to participate in the research described in this authorization and will not receive treatment as a study participant if you do not sign this form.

If you sign this authorization, you will have the right to revoke it at any time, except to the extent that the hospital has already taken action based upon your authorization or needs the information to complete analysis and reports of data for this research. This authorization will never expire unless and until you revoke it. To revoke this authorization, please write to Dr. Harmony Reynolds at the hospital.

You also have a right to receive a copy of this form after you have signed it.

SIGNATURE: I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above.

Signature of Subject or Personal Representative

Description of Personal Representative

Print Name of Subject or Personal Representative

Date:

CONTACT INFORMATION: The contact information of the subject or personal representative who signed this form should be filled in below:

Address:

_____

_____

Telephone: _____ (daytime) _____ (evening) _____(mobile)

Email:_____

*****THE SUBJECT OR HIS OR HER PERSONAL REPRESENTATIVE MUST BE PROVIDED WITH A COPY OF THIS FORM AFTER IT HAS BEEN SIGNED.