



**CANCELLATION OF PARTICIPATION IN A RESEARCH STUDY AND
 MODIFICATION OR CANCELLATION OF PATIENT AUTHORIZATION FOR
 USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**
 (References: 45 CFR 164.508 and 45 CFR 164.528)

RESEARCH STUDY INFORMATION (This section to be completed by the researcher.)	IRB #:
Name of Principal Investigator (P.I.):	
Address:	
Phone Number: (including area code)	
Title of the Research:	

Dear Researcher,

Note: You will not be able to type in this form from this point on.

I want to end my participation in this research study. I understand that the research staff will continue using my health information that they collected before the date that the research staff receives this form. However, they only will use this information for reasons discussed in the consent form that I signed when I joined this research study.

In addition to ending my active participation in this research study, I would like to (please choose one of the following statements):

CANCEL MY AUTHORIZATION TO USE AND DISCLOSE MY PRIVATE HEALTH INFORMATION
<input type="checkbox"/> I will <u>not</u> continue in this research study and the research staff will <u>not</u> collect any more information about me after the date this written, signed and dated request is received by the research staff. However, I understand that the research staff may continue to use information about me that was collected for the purpose of this research study <u>prior to</u> the date that this written, signed and dated request is received by the researcher. Also, I understand that in some cases the research staff may need to contact me even after I cancel my authorization in order to notify me of safety concerns or other new information about the research study.

CONTINUE MY AUTHORIZATION TO USE AND DISCLOSE MY PRIVATE HEALTH INFORMATION
<input type="checkbox"/> I will <u>not</u> actively continue in this research study after the date this written, signed and dated request is received by the research staff, but the research staff may <u>continue</u> collecting information from my medical record. This will be done only as needed for this research study and only for the reasons discussed in the consent form. Also, I understand that in some cases the research staff may need to contact me even after I cancel my authorization in order to notify me of safety concerns or other new information about the research study.

Optional: I am ending my participation in this research study because:

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Printed Name of Participant

Signature of Participant

Date

For Researcher Use Only (This box must appear on the same page as the section before it.)

I acknowledge receipt of this letter and will comply with the written request as stated above. I understand that it is my responsibility to promptly forward a copy of this request to Health Information Management upon its receipt and to maintain the original document with the research study records of this participant. If the participant has revoked his/her authorization for use and disclosure of private health information (PHI), I also understand that I must account for uses and disclosures of this participant's PHI in compliance with 45 CFR 164.528 following receipt of this request.	

Signature of Principal Investigator

Date