Authorization for the Use and Disclosure of Patient Health Information for Research Purposes

Authorization:

By signing this Authorization Form, I am allowing my therapist at the Oakland Cognitive Behavior Therapy Center (OCBTC) to use my Protected Health Information, as described below, and/or to disclose it to the members of the research team at the OCBTC and their trusted research collaborators as part of my participation in the research studies at the Oakland Cognitive Behavior Therapy Center (OCBTC), 5625 College Avenue, Suite 215, Oakland, CA 94618 and 510-662-8405.

I authorize the use and/or disclosure of the following Protected Health Information:

Demographic information: E.g., age, gender, race/ethnicity, education level, income level, marital status

Clinical information: E.g., diagnoses, psychiatric medications, symptom history, developmental history

Treatment information: E.g., number of therapy sessions, type of treatment I received, interventions I received, amount of therapy homework I completed, symptoms/behaviors I worked on

Symptom and other assessment measures: Responses to questionnaires collected by the OCBTC before, during, and after my treatment to assess my personal and treatment history, symptoms, and progress during treatment.

This Protected Health Information is being used or disclosed for research purposes: In support of our Center's mission to increase psychological well-being and reduce suffering caused by mental illness, the OCBTC is conducting a series of studies testing hypotheses about assessment procedures and measures, symptoms of psychopathology, and the process and outcome of cognitive behavior therapy. Examples of similar studies we have conducted are posted on our website at www.oaklandcbt.com/Research/Research Publications. We are asking permission to use the pieces of Protected Health Information described above in our research studies and in studies conducted by collaborators we trust.

I understand that research studies and conference and teaching presentations based on my PHI will be presented in a way that does not identify me.

This authorization will expire upon my written request.

I may revoke this authorization at any time by notifying my therapist in writing of my intent to revoke the authorization. When I withdraw my permission, no new health information will be gathered from me or my clinical record after that date. Information that has already been gathered may still be used and disclosed.

Information used or disclosed after this authorization form is signed may be subject to re-disclosure by my therapist and the OCBTC Research Team) and may not be protected by federal or state law. An example of an instance in which research data may be subject to re-disclosure would include when an oversight body (such as a human subjects review board, or a federal agency that oversees research) requests the data to help ensure the safety of participants.

I may inspect and receive a copy of the information that is used or disclosed after this authorization form is signed.

I have the right to not sign this authorization. I understand that if I do not sign this authorization I will not be able to contribute to the research studies at the Oakland CBT Center that are based on my Protected Health Information. I understand that my decision to not participate in these research studies is not a condition for receiving treatment at the OCBTC.

Name and Signature:

I have been given the information about the use and disclosure of my health information for the research studies conducted at the OCBTC. My questions have been answered.

I authorize the use and disclosure of my health information to the parties listed in the authorization section of this consent for the purposes described above.

Signature of Participant Date

_____ _____

Printed Name of Participant

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