

**THE UNIVERSITY OF ARIZONA HUMAN SUBJECTS PROTECTION PROGRAM**  
**AUTHORIZATION FORM FOR USE AND DISCLOSURE OF PROTECTED HEALTH**  
**INFORMATION (PHI) FOR RESEARCH**

*For IRB Office Use Only:*

APPROVED BY UNIVERSITY OF AZ IRB  
THIS STAMP MUST APPEAR ON ALL  
DOCUMENTS USED TO CONSENT SUBJECTS,  
DATE: **10-08-10** EXPIRATION: **10-08-11**

Project Title: **THE DNA SHOAH PROJECT**

**The United States government has issued a new privacy rule to protect the privacy rights of individuals enrolled in research. The Privacy Rule is designed to protect the confidentiality of an individual's health information. This document hereafter known as an "Authorization for Use and Disclosure of Protected Health Information for Research" describes your rights and explains how your health information will be used and disclosed for this study.**

**PURPOSE**

You are being invited to participate voluntarily in the above-titled research project. The purpose of collecting Protected Health Information (PHI) for this study is help researchers answer the questions that are being asked in this research study.

**WHAT INFORMATION MAY BE USED AND GIVEN TO OTHERS?**

Information that will be collected about you includes:

- Your name and contact information (address, phone, e-mail), as well as that of an alternate contact in the event that we are unable to reach you; your date and place of birth, along with any other names that you may have used in the past; the date of your immigration to the U.S., if applicable; the names of your family members, living and deceased; your saliva, via a buccal (cheek) swab.

**WHO MAY USE AND RECEIVE INFORMATION ABOUT ME?**

Information about you may be given out by the Principal Investigator and study personnel to:

- Representatives of regulatory agencies (including the University of Arizona Human Subjects Protection Program) to ensure quality of data and study conduct.

Our collaborator for this project, Gene Codes Forensics, Inc., will be responsible for genetic analysis of project samples. All samples will be assigned a unique sample identification number and thereby anonymized; NO IDENTIFYING INFORMATION will accompany data for analysis, nor will this information be shared.

**WHY WILL THIS INFORMATION BE USED AND/OR GIVEN TO OTHERS?**

- Anonymized genetic data will shared as described above. No other information will be shared or given to others.

The results of this research may be published in scientific journals or presented at professional meetings, but your identity will not be disclosed.

**HOW LONG WILL THIS INFORMATION BE USED AND/OR GIVEN TO OTHERS?**

Your PHI will be linked to your identifying information for the duration of the project. After this time, all links will be destroyed and your identity will not be able to be determined.

This authorization has no expiration date.

**MAY I REVIEW OR COPY THE INFORMATION OBTAINED FROM ME OR CREATED ABOUT ME?**

You have the right to access PHI that you have submitted as part of the intake process. The DNA Shoah Project will notify participants in the event that a match is made among participants, but we will not otherwise be returning a genetic profile or any genealogical information.

**MAY I WITHDRAW OR REVOKE (CANCEL) MY PERMISSION?**

Should you wish to cancel your authorization and withdraw from the project, your information will be destroyed. In the event that you wish to withdraw, please notify the Principal Investigator in writing: Dr. Michael Hammer, The DNA Shoah Project  
P.O. Box 210240, Tucson, AZ 85721.

**WHAT IF I DECIDE NOT TO GIVE PERMISSION TO USE AND GIVE OUT MY HEALTH INFORMATION?**

You may refuse to sign this authorization form. If you choose not to sign this form, you cannot participate in the research study. Refusing to sign will not affect your present or future medical care and will not cause any loss of benefits to which you are otherwise entitled.

**IS MY HEALTH INFORMATION PROTECTED AFTER IT HAS BEEN GIVEN TO OTHERS?**

Your information will not be used by or given to others.

**CONTACTS**

You can obtain further information from the Principal Investigator, Michael Hammer, PhD., at (520) 626-6203. If you have questions concerning your rights as a research subject, you may call the Human Subjects Protection Program office at (520) 626-6721. If you would like to contact the Human Subjects Protection Program via the web (this can be anonymous), please visit <http://orcr.vpr.arizona.edu/irb/contact>.

**AUTHORIZATION**

I hereby authorize the use or disclosure of my individually identifiable health information. I will be given a copy of this signed authorization form.

\_\_\_\_\_  
Subject's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Subject

\_\_\_\_\_  
Signature of Subject's Legal Representative (if necessary)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Subject's Legal Representative

\_\_\_\_\_  
Relationship to Subject