# Informed consent

**Department of**

## Title of Study:

## Investigator(s):

For questions or concerns about the study, you may contact       at      .

For questions regarding the rights of research subjects, any complaints or comments regarding the manner in which the study is being conducted, contact the UNLV Office of Research Integrity – Human Subjects at 702-895-0020 or via email at IRB@unlv.edu.

If you are conducting face-to-face procedures, please keep the statement in the box or delete this entire section if you are not conducting face-to-face procedures.

***It is unknown as to the level of risk of transmission of COVID-19 if you decide to participate in this research study. The research activities will utilize accepted guidance standards for mitigating the risks of COVID-19 transmission: however, the chance of transmission cannot be eliminated.***

## Purpose of the Study

You are invited to participate in a research study. The purpose of these study is      .

## Participants

You are being asked to participate in the study because you fit this criteria:      .

## Procedures

If you volunteer to participate in this study, you will be asked to do the following:

## Benefits of Participation

There Click & Choose One be direct benefits to you as a participant in this study. However, we hope to learn      .

## Risks of Participation

There are risks involved in all research studies. This study may include only minimal risks. *State the level of anticipated risks (i.e. you may become uncomfortable when answering some questions).*

## Cost /Compensation

There Click & Choose One be financial cost to you to participate in this study. The study will take       Click & Choose One of your time. You Click & Choose One be compensated for your time.

## Confidentiality

All information gathered in this study will be kept as confidential as possible. No reference will be made in written or oral materials that could link you to this study. All records will be stored in a locked facility at UNLV for       years after completion of the study. After the storage time the information gathered will be      .

## Voluntary Participation

Your participation in this study is voluntary. You may refuse to participate in this study or in any part of this study. You may withdraw at any time without prejudice to your relations with UNLV. You are encouraged to ask questions about this study at the beginning or any time during the research study.

## Participant Consent:

I have read the above information and agree to participate in this study. I have been able to ask questions about the research study. I am at least 18 years of age. A copy of this form has been given to me.

Signature of Participant Date

Participant Name (Please Print)

*If your study includes the use of audio/video taping, you must include a separate signature line for the consent to audio or video tape. Otherwise, delete this section*.

Audio/Video Taping:

*Use language similar to:*

I agree to be audio or video taped for the purpose of this research study.

Signature of Participant Date

Participant Name (Please Print)

*If your study includes the use of HIPAA protected health information, please include the following*:

**Authorization to Use or Disclose (Release) Health Information that Identifies You for a Research Study**

If you sign this document, you give permission to [name or other identification of specific health care provider(s) or description of classes of persons, e.g., all doctors, all health care providers] at [name of covered entity or entities] to use or disclose (release) your health information that identifies you for the research study described above.

The health information that we may use or disclose (release) for this research includes [complete as appropriate]:

[Provide a description of information to be used or disclosed for the research project. This may include, for example, all information in a medical record, results of physical examinations, medical history, lab tests, or certain health information indicating or relating to a particular condition.]

The health information listed above may be used by and/or disclosed (released) to:

[Name or class of persons involved in the research; i.e., researchers and their staff[\*\*](https://privacyruleandresearch.nih.gov/authorization.asp#FOOTNOTE2)]

[Name of covered entity] is required by law to protect your health information. By signing this document, you authorize [name of covered entity] to use and/or disclose (release) your health information for this research. Those persons who receive your health information may not be required by Federal privacy laws (such as the Privacy Rule) to protect it and may share your information with others without your permission, if permitted by laws governing them.

Please note that [include the appropriate statement]:

You do not have to sign this Authorization, but if you do not, you may not receive research-related treatment.   
**(When the research involves treatment and is conducted by the covered entity or when the covered entity provides health care solely for the purpose of creating protected health information to disclose to a researcher)**

[Name of covered entity] may not condition (withhold or refuse) treating you on whether you sign this Authorization.   
**(When the research does not involve research-related treatment by the covered entity or when the covered entity is not providing health care solely for the purpose of creating protected health information to disclose to a researcher)**

Please note that [include the appropriate statement]:

You may change your mind and revoke (take back) this Authorization at any time, except to the extent that [name of covered entity(ies)] has already acted based on this Authorization. To revoke this Authorization, you must write to: [name of the covered entity(ies) and contact information].   
**(Where the research study is conducted by an entity other than the covered entity)**

You may change your mind and revoke (take back) this Authorization at any time. Even if you revoke this Authorization, [name or class of persons at the covered entity involved in the research] may still use or disclose health information they already have obtained about you as necessary to maintain the integrity or reliability of the current research. To revoke this Authorization, you must write to: [name of the covered entity(ies) and contact information].   
**(Where the research study is conducted by the covered entity)**

This Authorization does not have an expiration date [or as appropriate, insert expiration date or event, such as "end of the research study."]

Signature of participant or participant’s Date

personal representative

Printed name of participant or participant’s If applicable, a description of the personal

personal representative representative’s authority to sign for the participant

## OPTIONAL ELEMENTS:

Examples of optional elements that may be relevant to the recipient of the protected health information:

* Your health information will be used or disclosed when required by law.
* Your health information may be shared with a public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, and conducting public health surveillance, investigations or interventions.
* No publication or public presentation about the research described above will reveal your identity without another authorization from you.
* If all information that does or can identify you is removed from your health information, the remaining information will no longer be subject to this authorization and may be used or disclosed for other purposes.
* **When the research for which the use or disclosure is made involves treatment and is conducted by a covered entity:** To maintain the integrity of this research study, you generally will not have access to your personal health information related to this research until the study is complete. At the conclusion of the research and at your request, you generally will have access to your health information that [name of the covered entity] maintains in a designated record set, which means a set of data that includes medical information or billing records used in whole or in part by your doctors or other health care providers at [name of the covered entity] to make decisions about individuals. Access to your health information in a designated record set is described in the Notice of Privacy Practices provided to you by [name of covered entity]. If it is necessary for your care, your health information will be provided to you or your physician.
* If you revoke this Authorization, you may no longer be allowed to participate in the research described in this Authorization.