



PACIFIC GRADUATE SCHOOL OF PSYCHOLOGY (PGSP)
**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
FOR RESEARCH PURPOSES**

Study Title: A Study of the Efficacy of NeuroModulation Technique in Children with Autism
Principal Investigator: Roger L. Greene, Ph.D.
Study Chair: Robert H. Weiner, Ph.D.
Date of PGSP IRB Approval: April 8, 2007

Participant Name: _____

On April 14, 2003, HIPAA (Health Insurance Portability & Accountability Act) began to allow individuals to control how their private health information is used. You as parent or legal guardian have been asked to give permission for your child to participate in this study listed above. This Authorization gives you information about the use and disclosure of your child's health information for this research, and requests your permission to use and share your child's individual health information.

The purpose of this study is to determine the effectiveness of NeuroModulation Technique (NMT) in reducing the symptoms of autism.

This protected health information will be used for the research purposes described in the Consent Form for the study named above. You will be given a copy of this Consent Form.

Individual Health Information to be used or Disclosed: By signing this document, you will authorize the parties listed below to provide the principal investigator and members of the research team access to the following information about your child:

- | | |
|--|---|
| <input checked="" type="checkbox"/> Test inventories and questionnaires | <input checked="" type="checkbox"/> Videotapes, audiotapes or photographs |
| <input checked="" type="checkbox"/> Letter or report confirming autism diagnosis | <input checked="" type="checkbox"/> NMT session records |

Parties Who May Receive or Use Your Individual Health Information:

The research team may also need to disclose the information to others as part of the study process. This may include:

The Principle Investigator, Roger L. Greene, Ph.D., the Study Chair, Robert H. Weiner, Ph.D. and The PGSP Institutional Review Board

No individual identities will be used in any reports or publications resulting from this study. Data and/or videotapes may be used as an educational teaching tool for those who are not members of

the research team (for example, at conferences and symposiums on autism and/or NMT), but no individual identities will be revealed.

Duration of Investigator Access and Use of your Individual Health Information:

Your child's health information cannot be used indefinitely without your knowledge. This authorization to access and use your child's individual health information will expire 10 years from the conclusion of this study.

Right to Refuse to Sign this Authorization:

This Authorization to release health information is voluntary. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing or refusing to sign this Authorization with some exceptions. If you decide not to sign this Authorization your child will not participate in this research study or receive research related treatment.

Right to Revoke Your Authorization:

You can cancel your Authorization to allow use of your child's health information at any time by:

1. Writing to the Principal Investigator identified in the Informed Consent Form, or
2. Informing the Study Chair or member of the research team that you wish to revoke this Authorization. They may ask you to fill out a form.

If you revoke this Authorization, the investigator and the research team can continue to use information about your child that was collected before receipt of the revocation. The research team will not collect information about your child after you revoke the Authorization.

Potential for Re-disclosure

Once your child's health information is disclosed to the research team it is not protected under HIPAA. By signing this Authorization you allow that disclosure. Although HIPAA no longer protects any of your child's health information that you have disclosed to the research team, the research team will continue to protect your child's personally identifiable health information as described in the Consent Form. PGSP complies with the requirements of HIPAA and its privacy regulations, and with all other applicable laws that protect the confidentiality of your health information.

Name of Subject/Child (Please Print)

Name of Parent or Guardian Granting Authorization	Relationship to Child (Please Print)	Signature	Date
---	--------------------------------------	-----------	------

Name of Parent or Guardian Granting Authorization	Relationship to Child (Please Print)	Signature	Date
---	--------------------------------------	-----------	------