

Form A

HIPAA Clinical Research Authorization

Protocol Number: AAAA8505

Genomic Analysis of Pilocyroid Astrocytoma

PI: Dr. Jeffrey N. Bruce

I agree to permit Columbia University Health Sciences, my doctors, and my other health care providers (together “Providers”), and Dr. Jeffrey N. Bruce and his staff (together “Researchers”), to use and disclose health information about me as described below.

1. The health information that may be used and disclosed includes:

- all information collected during the research described in the Informed Consent Form for the above-named study (“the Research”); and
- health information in my medical records that is relevant to the Research.

2. The Providers may disclose health information in my medical records to:

- the Researchers;
- the sponsor of the Research, Dr. Jeffrey N. Bruce, and its agents and contractors (together “Sponsor”); and
- representatives of government agencies, review boards, and other persons who watch over the safety, effectiveness, and conduct of research.

3. The Researchers may use and share my health information:

- among themselves and with other participating researchers to conduct the Research; and
- as permitted by the Informed Consent Form.

4. The Sponsor may use and share my health information as permitted by the Informed Consent Form.

5. Once my health information has been disclosed to a third party (e.g., a pharmaceutical company participating in this Study), federal privacy laws may no longer protect it from further disclosure.

6. Please note that:

- You do not have to sign this Authorization, but if you do not, you may not participate in the Research.
- You may change your mind and revoke (take back) this Authorization at any time and for any reason. To revoke this Authorization, you must write to Privacy Officer, Columbia University Health Sciences, 601 West 168th Street, Apt. 22, New York, N.Y. 10032. However, if you revoke this Authorization, you will not be allowed to continue taking part in the Research. Also, even if you revoke this Authorization, the Researchers and the Sponsor may continue to use and disclose the information they have already collected as permitted by the Informed Consent Form.
- While the Research is in progress, you may not be allowed to see your health information that is created or collected by Columbia University in the course of the Research. After the Research is finished, however, you may see this information as described in Columbia University’s Notice of Privacy Practices.

7. This Authorization does not have an expiration (ending) date.

8. You will be given a copy of this Authorization after you have signed it.

Signature of participant or participant's legal
representative

Printed name of participant
Date

Printed name of legal representative (if applicable)

Representative's relationship to participant