**Insert your organization logo or print on your letterhead**

**Study Description**

**What it Means to Participate in the Name of your Research or Evaluation Project Study**

*You are being invited to take part in a research study. Please read this document carefully. Please feel free to ask as many questions as you like before deciding whether to participate.*

These are examples; insert applicable language.

## Purpose of the Study

The purpose of the study is to learn more about how health care is coordinated. Care coordination may include care planning, patient education, monitoring of symptoms, arranging for services and help with communication among the providers caring for you.

**Procedures**

If you decide to take part in this study, a member of the research team will interview you about how your health care is coordinated. In addition, after obtaining your permission, the researcher will also review your health records and discuss your case with your care coordinator or case manager, and, possibly your physician/nurse practitioner and family members.

**Explanation of Risks & Protecting Your Privacy**

There is little or no risk to participating in this study. We will keep private any information we collect about you for this study. Your name and any other personal information about you will be used only for research purposes. We will assign an identification number to information about you so that your name will not appear on any records or reports in this study. When the study is completed, we will destroy any private information we have about you.

## Access of Research Team to Your Existing Health and Other Private Information

If you decide to participate in this study, you will also be asked to authorize or consent to the sharing of you private health information. This includes your health records. You may cancel this consent with written notice at any time, but this written notice will not affect information that has already been requested or released. **Researchers will not publicly share any information that could be used to identify you.**

## Costs and Payment

There is no cost to you for participating in this study. You will not be paid for your participation in this study.

**Voluntary Participation & Disclosure of Health and Private Information**

You do not have to take part in this study or agree to release medical records or private information. Your decision to participate in the study and release private information is completely voluntary. Your decision not to participate, to withdraw, or to not release records will not affect your health care treatment or benefits in any way.

By agreeing to participate and by signing this form, you are not giving up or waiving any of your legal rights. However, you are agreeing to allow researchers to obtain private information about you for the reasons described above.

If you change your mind about participating, you can withdraw from the study at any time by writing or calling **[insert project-appropriate name and/or other contact information]**.

Principal Investigator: [insert name, job title, contact information]

Co-Investigator: [insert name, job title, contact information]

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**Agreement to Participate in the [Name of your Research or Evaluation Project] Study & Authorization to Obtain and Share My Private Information**

I have read this Agreement and the Study Description or have had it explained to me and I understand its contents. I have been given the chance to ask questions about the study and all of my questions have been answered to my satisfaction. I understand that if I have other questions about this study or concerns about my privacy, I can contact [insert project-appropriate name and/or other contact information]. If I do not consent to give protected information to the research team or if I withdraw my consent, I understand I may not be able to participate in the study.

I understand that State and Federal privacy laws protect my health records and other protected information about me. My private information can be released only if I give my written permission or if the law allows it. If I refuse to sign or cancel this release, services or benefits I currently receive will not be effected in any way. I understand that I may cancel this consent with written notice at any time, but that that notice when provided will not affect information the agency has already requested and or released.

**Study Duration & Authorization (Consent to Release Information) Expiration Date**

This study is expected to end by [insert date]. The authorization to release my private information ends [insert date – must be within one year of date when authorization form is signed].

Effect of Signing This Form By signing below:

* I authorize the research team, the Minnesota Department of Human Services, and my health care coordinator(s), case manager(s), plan(s) and providers to share my private health and other protected information.
* I agree to participate in this study. I agree to participate in interviews by the research team.
* I acknowledge that I have received a Notice of Privacy Practices and that its purpose and contents have been explained to me.

Participant Signature Date Participant Printed Name

Person Authorized to Sign Date Relationship of Person Authorized to Sign

Witness to Signature (if necessary) Date