THE OHIO STATE UNIVERSITY
AUTHORIZATION TO USE
PERSONAL HEALTH INFORMATION IN RESEARCH

Title of the Study: The Gut Feelings Study: Marriage, Mood and the Gut Microbiome

Protocol Number: 2016H0295

Principal Investigator: Janice Kiecolt-Glaser, PhD

Subject Name_____

Before researchers use or share any health information about you as part of this study, The Ohio State University is required to obtain your authorization. This helps explain to you how this information will be used or shared with others involved in the study.

- The Ohio State University and its hospitals, clinics, health-care providers, and researchers are required to protect the privacy of your health information.
- You should have received a Notice of Privacy Practices when you received health care services here. If not, let us know and a copy will be given to you. Please carefully review this information. Ask if you have any questions or do not understand any parts of this notice.
- If you agree to take part in this study your health information will be used and shared with others involved in this study. Also, any new health information about you that comes from tests or other parts of this study will be shared with those involved in this study.
- Health information about you that will be used or shared with others involved in this study may include your research record and any health care records at The Ohio State University. For example, this may include your medical records, x-rays, or laboratory results. Psychotherapy notes in your health records (if any) will not, however, be shared or used. Use of these notes requires a separate, signed authorization.

Please read the information carefully before signing this form. Please ask if you have any questions about this authorization, the university's Notice of Privacy Practices or the study before signing this form.

Those Who May Use, Share, and Receive Your Information as Part of This Study

- Researchers and staff at The Ohio State University will use, share, and receive your personal health information for this research study. Authorized Ohio State staff not involved in the study may be aware that you are participating in a research study and have access to your information. If this study is related to your medical care, your study-related information may be placed in your permanent hospital, clinic, or physician's office records.

Initials/Date: _____

- Those who oversee the study will have access to your information, including the following:
    - Members and staff of The Ohio State University's Institutional Review Boards, including the Western Institutional Review Board
    - The Ohio State University Office of Responsible Research Practices
    - University data safety monitoring committees
    - The Ohio State University Office of Research.

- Your health information may also be shared with federal and state agencies that have oversight of the study or to whom access is required under the law. These may include the following:
    - Food and Drug Administration
    - Office for Human Research Protections
    - National Institutes of Health
    - Ohio Department of Job and Family Services.

- These researchers, companies and/or organization(s) outside of The Ohio State University may also use, share and receive your health information in connection with this study:
    - Health care facilities, research site(s), researchers, health care providers, or study monitors involved in this study:
        - None

The information that is shared with those listed above may no longer be protected by federal privacy rules.

Authorization Period

This authorization will not expire unless you change your mind and revoke it in writing. There is no set date at which your information will be destroyed or no longer used. This is because the information used and created during the study may be analyzed for many years, and it is not possible to know when this will be completed.

Initials/Date_____

Signing the Authorization

- You have the right to refuse to sign this authorization. Your health care outside of the study, payment for your health care, and your health care benefits will not be affected if you choose not to sign this form.
- You will not be able to take part in this study and will not receive any study treatments if you do not sign this form.
- If you sign this authorization, you may change your mind at any time. Researchers may continue to use information collected up until the time that you formally changed your mind. If you change your mind, your authorization must be revoked in writing. To revoke your authorization, please write to:

  Janice Kiecolt-Glaser at, Institute for Behavioral Medicine Research, Ohio State University College of Medicine, 460 Medical Center Dr, Room 130, Columbus, Ohio 43210-1257

  OR HIPAA Privacy Manager, The Ohio State University Medical Center, Suite E2140, 600 Ackerman Road, Columbus, Ohio 43202
- Signing this authorization also means that you will not be able to see or copy your study-related information until the study is completed. This includes any portion of your medical records that describes study treatment.

Contacts for Questions

- If you have any questions relating to your privacy rights, please contact:

  HIPAA Privacy Manager, Ohio State University Medical Center
  Suite E2140, 600 Ackerman Road
  Columbus, OH 43202
- If you have any questions relating to the research, please contact:

  Dr. Janice Kiecolt-Glaser, (614) 293-3499
  Institute for Behavioral Medicine Research
  Ohio State University College of Medicine
  460 Medical Center Dr., Room 130
  Columbus, Ohio 43210-1228

Signature

I have read (or someone has read to me) this form and have been able to ask questions. All of my questions about this form have been answered to my satisfaction. By signing below, I permit Janice Kiecolt-Glaser and the others listed on this form to use and share my personal health information for this study. I will be given a copy of this signed form.

Signature_____
(Subject or Legally Authorized Representative)

Print Name _____ Date_____ Time _____ AM/PM

_____
(If legal representative, also print relationship to subject)

Notice of Privacy Practices Acknowledgement

Your privacy is important to us. We are committed to protecting all of the health information we gather from you. The Notice of Privacy Practices describes your rights with regard to your health information, as well as how we may use your health information, and how we must protect the confidentiality of your health information. Every person who may access your information is bound by our confidentiality requirements, as outlined in our Notice of Privacy Practices.

We encourage you to carefully read the Notice, and to contact the research project director at **(614) 293-3499** if you need more information. You may also access our Notice of Privacy Practices on our website, http://www.stressandhealth.org/.

I have received the Notice of Privacy Practices.

Signature: _____ Date: _____