

**The University of Texas Southwestern Medical Center at Dallas  
Children's Medical Center, Parkland Health & Hospital System  
Retina Foundation of the Southwest, Texas Scottish Rite Hospital for Children  
Zale Lipshy University Hospital, St. Paul University Hospital  
The University of Texas Southwestern Moncrief Cancer Center**

**Authorization for Use and Disclosure of  
Health Information for Research Purposes**

NAME OF RESEARCH PARTICIPANT: \_\_\_\_\_

1. You agree to let UT Southwestern Medical Center, Parkland Hospital, The General Clinical Research Center, share your health information with Dr. Abhimanyu Garg and his or her staff at the University of Texas Southwestern Medical Center at Dallas ("Researchers") for the purpose of the following research study: Physical and Metabolic Abnormalities in Lipodystrophy, A study to understand different types of fat variations, such as fat loss or fat redistribution and the underlying genetic basis. IRB File # 1093-37500

2. You agree to let the Researchers use your health information for this Research Project. You also agree to let the Researchers share your health information with others who may be working with the Researchers on the Research Project ("Recipients") as follows.

- NIH ( National Institutes of Health ). The sponsor includes any people, entities, groups or companies working for or with the sponsor or owned by the sponsor. The sponsor will receive written reports about your participation in the research. The sponsor may look at your health information to assure the quality of the information used in the research.
- Rogers MRI, GCRC Core Lab, Mineral Metabolism Lab, Quest lab, Aston Radiology. These are other research facilities that are working with UT Southwestern on the Research Project.
- The UT Southwestern Institutional Review Board (IRB). This is a group of people who are responsible for assuring that the rights of participants in research are respected. Members and staff of the IRB at UT Southwestern may review the records of your participation in this research. A representative of the IRB may contact you for information about your experience with this research. If you do not want to answer their questions, you may refuse to do so.
- Representatives of the Office of Human Research Protections (OHRP). The OHRP may oversee the Research Project to confirm compliance with laws, regulations and ethical standards.

3. Whenever possible your health information will be kept confidential. Federal privacy laws may not apply to some institutions outside of UT Southwestern. There is a risk that the Recipients could share your information with others without your permission. UT Southwestern cannot guarantee the confidentiality of your health information after it has been shared with the Recipients.

4. You agree to permit the Researchers to use and share your health information as listed below: Medical history, physical exams, DEXA scans, MRI scans, MRS scans, blood tests, urine tests, pregnancy tests, biopsies, HIV status, current and previous medications, questionnaires, and photographs and DNA testing if applicable .

5. The Researchers may use your health information to create research data that does not identify you. Research data that does not identify you may be used and shared by the Researchers (for example, in a publication about the results of the Research Project); it may also be used and shared by the Researchers and Recipients for other research purposes not related to the Research Project.

6. This authorization is voluntary. Your health care providers must continue to provide you with health care services even if you choose not to sign this authorization. However, if you choose not to sign this authorization, you cannot take part in this Research Project.

7. This Authorization has no expiration date.

8. If you change your mind and do not want us to collect or share your health information, you may cancel this authorization at any time. If you decide to cancel this authorization, you will no longer be able to take part in the Research Project. The Researchers may still use and share the health information that they have already collected before you canceled the authorization. To cancel this authorization, you must make this request in writing to:

Claudia Quittner  
UT Southwestern Medical Center  
5323 Harry Hines Blvd.  
Dallas, Texas 75390-9052  
Phone 214-648-9296

9. A copy of this authorization form will be provided to you.

\_\_\_\_\_  
Signature of Research Participant

\_\_\_\_\_  
Date

**For Legal Representatives of Research Participants (if applicable):**

Printed Name of Legal Representative: \_\_\_\_\_

Relationship to Research Participant: \_\_\_\_\_

*I certify that I have the legal authority under applicable law to make this Authorization on behalf of the Research Participant identified above. The basis for this legal authority is:*

\_\_\_\_\_  
(e.g. parent, legal guardian, person with legal power of attorney, etc.)

\_\_\_\_\_  
Signature of Legal Representative

\_\_\_\_\_  
Date

