Authorization To Use Your Health Information For Research Purposes

Because information about you and your health is personal and private, it generally cannot be used in this research study without your written authorization. If you sign this form, it will provide that authorization. The form is intended to inform you about how your health information will be used or disclosed in the study. Your information will only be used in accordance with this authorization form and the informed consent form and as required or allowed by law. Please read it carefully before signing it.

What is the purpose of this research study and how will my health information be utilized in the study?

The purpose of this research program is to study the new technology of magnetic resonance imaging (MRI). This includes new imaging software and RF coils (radiowave antennae). This new machine uses a strong magnet field to make images of the inside of the body. Any information that may be published in scientific journals will not reveal the identity of the subjects. Patient information will be provided to Federal and regulatory agencies as required. The Food and Drug Administration, for example, may inspect research records and learn your identity if this study falls within its jurisdiction.

Do I have to sign this authorization form?

You do not have to sign this authorization form. But if you do not, you will not be able to participate in this research study. Signing the form is not a condition for receiving any medical care outside the study.

If I sign, can I revoke it or withdraw from the research later?

If you decide to participate, you are free to withdraw your authorization regarding the use and disclosure of your health information (and to discontinue any other participation in the study) at any time. After any revocation, your health information will no longer be used or disclosed in the study, except to the extent that the law allows us to continue using your information (e.g., necessary to maintain integrity of research). If you wish to revoke your authorization for the research use or disclosure of your health information in this study, you must contact the Protocol Director: Gary H. Glover, Ph.D. at (650) 723-7577.

What Personal Information Will Be Used or Disclosed?

Your health information related to this study, may be used or disclosed in connection with this research study, including, but not limited to magnetic resonance imaging scans may be used or disclosed in connection with this study.

Who May Use or Disclose the Information?
The following parties are authorized to use and/or disclose your health information in connection with this research study:

The Protocol Director: **Dr. Gary Glover**
The Stanford University Administrative Panel on Human Subjects in Medical Research
and any other unit of Stanford University as necessary.
The Study Coordinators and the research team

Who May Receive / Use the Information?
The parties listed in the preceding paragraph may disclose your health information to the following persons and organizations for their use in connection with this research study:
• The Office for Human Research Protections in the U.S. Department of Health and Human Services
• Food and Drug Administration.

Your information may be re-disclosed by the recipients described above, if they are not required by law to protect the privacy of the information.

When will my authorization expire?
Your authorization for the use and/or disclosure of your health information will expire on 12/31/2025.

Will access to my medical record be limited during the study?
To maintain the integrity of this research study, you may not have access to any health information developed as part of this study until it is completed.

_____
Signature of Subject

_____
Signature of Legally Authorized Representative

_____
Date

Description of Representative's Authority to Act for Subject