HIPAA Form A

HIPAA Clinical Research Authorization for Sponsored Research

Protocol Number: IRB-AAAR4378
Name of Study: Precision Medicine for Cardiovascular and Metabolic Disorders
Principal Investigator: Muredach Reilly

For the purpose of the conduct of the above name study, I agree to permit Columbia University Medical Center, my doctors, and my other health care providers (together "Providers"), and Muredach Reilly and his/her 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.
   - This may include medical history information that may be considered sensitive, including:

     Not applicable.

2. **The providers may disclose health information in my medical records to:**
   - the Researchers;
   - the sponsor of the Research, National Center for Advancing Transnational Sciences , 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 the research.

3. **The researchers may use and share my health information:**
   - among themselves and with other participating researchers to conduct the Research;
   - representatives of government agencies, review boards, and other persons who watch over the safety, effectiveness, and conduct of 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, 630 West 168th Street, Box 159, 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 be allowed to see this information.

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.

Printed Name of Subject: _____

Signature of Subject or Legal Representative: _____ Date: _____

Relationship of Legal Representative to Subject (if applicable): _____