Your Name: _____ Date of Birth: _____ Study ID _____

Research Authorization Form (University of Wisconsin-Madison)

Protocol Title: A Team Model of Hypertension Care in African Americans
Principal Investigator: Bonnie L. Svarstad, PhD

Researchers are required to get written permission to use your health information. This permission is called an "Authorization." To take part in this research, you must sign this Authorization form.

A. How will my health information be used? Your information will be used to evaluate a new pharmacy service for people with high blood pressure.

B. What health information will be used? Researchers will use information from your pharmacy records. This includes information about your drugs, blood pressure care, and contacts between your pharmacy and doctor. Researchers may contact insurance carriers about services and medications used.

C. Who will use my health information?
1. Your pharmacy will share information from your pharmacy records. Your insurance carrier will share information about your use of services and medications.
2. This information will be used by researchers from the UW-Madison, Medical College of Wisconsin, University of Illinois at Chicago, and University of Kansas. Data related to patient safety may be reviewed by the researchers' Institutional Review Boards and a Data Safety and Monitoring Board required by the study sponsor. The study sponsor is the National Heart, Lung, and Blood Institute.

D. How long will my permission last? This Authorization does not have an end date. However, you can withdraw your permission at any time. No new information will be used after you withdraw permission. Any health information that was shared before you withdrew will continue to be used. After this Authorization ends, you cannot take part in this research study. Withdrawal of your permission should be made in writing to: Bonnie L. Svarstad, PhD, UW-Madison School of Pharmacy, 777 Highland Avenue, Madison WI 53705-2222.

E. Is my permission voluntary? Your permission is voluntary. You may refuse to sign this form. Your pharmacy must continue to provide care to you even if you do not sign this form. If you do not sign this form, however, you cannot take part in this research study.

F. How will my health information be protected? Whenever possible your health information will be kept confidential. More information can be found in the consent form for this research study.

G. Questions. You should take as much time as you need to make your decision about this Authorization. Please ask any questions you might have about this Authorization form.

Certification: I have read this Authorization form. I have had a chance to ask questions and I have received answers to my questions. I agree to the use of my health information for this research study.

My signature: _____ Date: _____

** You should receive a copy of this form after signing it**