HIPAA[1] AUTHORIZATION TO USE AND DISCLOSE
INDIVIDUAL HEALTH INFORMATION FOR RESEARCH PURPOSES

Purpose. As the parent/guardian of a research participant, I authorize Susanna Magee and the researcher's staff to use and disclose my child's individual health information for the purpose of conducting the research project entitled: **Home Phototherapy for Neonatal Jaundice: A Comparison Between the Little Sparrows Bili·Hut™ and the Medela Bilibed®, Assessing the Treatment Duration, Parental Satisfaction, Impact on Breastfeeding Duration and Exclusivity, and Health Care Costs.**

Individual Health Information to be Used or Disclosed. My child's individual health information that may be used or disclosed to conduct this research includes: **Age, race, sex, bilirubin levels, phototherapy length of treatment and treatment outcome, breast feeding outcomes, etc.**

Parties Who May Disclose My Individual Health Information. The researcher and the researcher's staff may obtain my child's individual health information from:

Susanna Magee, MD, MPH, Landmark Medical Center, 115 Cass Avenue, Woonsocket, Rhode Island 02895

Parties Who May Receive or Use My Individual Health Information. The individual health information disclosed by parties listed above and information disclosed by me during the course of the research may be received and used by **Susanna Magee, MD** and the researchers at **Landmark Medical Center and Healthy Babies, Happy Moms Inc.**

Right to Refuse to Sign this Authorization. I do not have to sign this Authorization. If I decide not to sign the Authorization, I will not be allowed to participate in this study or receive any research related treatment that is provided through the study. However, my decision not to sign thisauthorization will not affect any other treatment, payment, or enrollment in health plans or eligibility for benefits.

Right to Revoke. This authorization does not expire, unless and until I revoke my authorization as described above. I can change my mind and withdraw this authorization at any time by sending a written notice to: **Susanna Magee, MD** to inform the researcher of my decision. If l withdraw this authorization, the researcher may only use and disclose the protected health information already collected for this research study. No further health information about me will be collected by or disclosed to the researcher for this study.

[1] HIPAA is the Health Insurance Portability and Accountability Act of 1996, a federal law related to privacy of health information.
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Potential for Re-disclosure. My child's individual health information disclosed under this authorization may be subject to re-disclosure outside the research study and no longer protected. For example, researchers in other studies could use my child's individual health information collected for this study without contacting me if they get approval from an Institutional Review Board (IRB) and agree to keep my information confidential.

Also, there are other laws that may require my child's individual health information to be disclosed for public purposes. Examples include potential disclosures if required for mandated reporting of abuse or neglect, judicial proceedings, health oversight activities and public health measures.

Suspension of Access. I may not be allowed to review the information collected for this study, including information recorded in my child's medical record, until after the study is completed. When the study is over, I will have the right to access the information again.

This authorization does not have an expiration date.

I am the parent/ guardian of the research participant.

I have read this information, and I will receive a copy of this authorization form after it is signed.

_____
Name of the Infant Research Participant

_____
Signature of the Parent/Guardian of the Research Participant

_____
Name of the Parent/Guardian of the Research Participant

_____
Date