**Withdrawal of HIPAA Consent for the Disclosure of Protected Health Information for Research Purposes**

**Date:**

**Name of Principal Investigator:**

**Study Title:**

**IRB Study Number:**

Dear Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

I am formally withdrawing the Research Subject Authorization for Confidentiality & Privacy Rights that I initially agreed to on \_\_\_\_\_\_\_\_\_\_\_\_\_\_.

By retracting my permission for the use or release of my Protected Health Information:

* I understand I will no longer be part of the referenced research study.
* My personal data gathered before my retraction may still be utilized if it is deemed essential for the continuity and validity of the research.

Kindly confirm receipt of this letter by signing below and returning a copy to me.

Sincerely,

Please sign your name here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Enter the current date here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please print your name here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate your mailing address here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Acknowledgment of Receipt:**

The printed name of the Principal Investigator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Principal Investigator:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Principal Investigator’s mailing address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_