HIPAA Authorization

For the Use of Patient Health Information for Research

Research Title:	A Phase 2 trial of cabozantinib and pembrolizumab in the first-line treatment of advanced hepatocellular carcinoma
Lead researcher:	Gentry King, MD
Institution of lead researcher:	University of Washington

A. Purpose of this form

The purpose of this form is to give your permission to the research team to obtain and use your patient information. Your patient information will be used to do the research named above.

State and federal privacy laws protect your patient information. These laws say that, in most cases, your health care provider can release your identifiable patient information to the research team only if you give permission by signing this form.

You do not have to sign this permission form. If you do not, you will not be allowed to join the research study. Your decision to not sign this permission will not affect any other treatment, health care, enrollment in health plans or eligibility for benefits.

B. The patient information that will be obtained and used

“Patient information” means the health information in your medical or other healthcare records. It also includes information in your records that can identify you. For example, it can include your name, address, phone number, birthdate, and medical record number.

1. Location of patient information

By signing this form you are giving permission to the following organization(s) to disclose your patient information for this research.

- UW Medicine (includes University of Washington Medical Center & Clinics)
- Fred Hutchinson Cancer Center
- Healthcare providers and laboratories who provide services for this study

2. Patient information that will be released for research use

This permission is for the health care provided to you during the following time period:

The specific information that will be released and used for this research is described below:

- All records

C. How your patient information will be used

1. Who may receive your patient information

    - The Principal Investigator and any persons or companies that are working with or for the Principal Investigator.
    - Researchers involved with this study
    - Department of Health and Human Services (DHHS) agencies
    - Governmental agencies in other countries
    - Governmental agencies to whom certain diseases (reportable diseases) must be reported
    - Fred Hutchinson Cancer Center IRB
    - Institutional oversight review offices at the research site, the UW, or state
    - Data & Safety Monitoring Committee (DSMC)

2. Why your patient information will be used and/or given to others

    - To do the research
    - To study the results, and
    - To see if the research was done right

If the results of this study are made public, information that identifies you will not be used.
The researcher will use your patient information only in the ways that are described in the research consent form that you sign and as described in this HIPAA Authorization.

You can ask questions about what the research team will do with your information and how they will protect it.

The privacy laws do not always require the receiver of your information to keep your information confidential. After your information has been given to others, there is a risk that it could be shared without your permission.

You have the right to obtain your patient information in your healthcare record. The study procedures do not include a plan to share your research results, though you may be able to request them through the Washington State Public Records request system after the study is done.

D. Expiration

This permission for the researchers to obtain your patient information: ends when the research ends and any required monitoring of the study is finished.

E. Canceling your permission

You may change your mind at any time. To take back your permission, you must send your **written** request to:

Gentry King, MD
Fred Hutchinson Cancer Center
825 Eastlake Avenue East, LG-465
Seattle, WA 98109, USA

If you take back your permission, the research team may still keep and use any patient information about you that they already have. But they can't obtain more health information about you for this research unless it is required by a federal agency that is monitoring the research.

If you take back your permission, you will need to leave the research study. This means that you would not have any more research treatments or tests. Changing your mind will not affect any other treatment, payment, health care, enrollment in health plans or eligibility for benefits.

F. Giving permission

I have read this HIPAA Authorization form describing how my patient information will be used. I have had a chance to ask questions about the use of my patient information and I have received answers to my questions. I agree to the use of my patient information for this research.

To release the specific information listed below, you need to also write your initials next to the type of information. This is your specific permission for release of this information, which is required by Federal and state laws. The federal rules bar any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

___________ Sexually transmitted disease
___________ AIDS or HIV
___________ Behavioral or mental health/illness, including psychotherapy notes
___________ Drug or alcohol abuse, diagnosis, or treatment

____
Printed Name of Research Subject Birthdate

____
Signature of Research Subject Date of signature

---------------------------- Use this witness/interpreter section only if applicable --------------------
If this HIPAA Authorization form is read to the participant because the participant is unable to read the English form, an impartial witness not affiliated with the research or investigator must be present for the consent and sign the following statement:
I confirm that the information in the consent form and any other written information was accurately explained to, and apparently understood by, the participant. The participant freely consented to be in the research study.

____
Impartial Witness/Interpreter Name

____
Signature of Impartial Witness/Interpreter Date of signature

You will receive a copy of this signed form. Please keep it with your personal records.