Protocol Title: Epidemiology of Sleep Disordered Breathing
Sleep Cohort Study Out-patient

Principal Investigator Name: Terry Young, Ph.D.

Version Date: 9/1/03

IRB #: 1988-082

Research Authorization Form
University of Wisconsin-Madison

Researchers at the University of Wisconsin-Madison (UW) are required to get written permission to use health information from the people taking part in a research study. This permission is called an "Authorization." In order to take part in this research study you must sign this Authorization form.

A. How will my health information be used?

The data we collect will be used, without any person identifiers, in statistical analyses to study the possible relationship between sleep-disordered breathing and cardiovascular disease.

B. What information will be used?

The following information about your health will be used for this research study: Information from you about your health, and information about your health obtained from the research activities of this study.

C. Who will use my health information?

The people who hold your medical records will share your health information with the UW-Madison researchers, who may also share with other people outside UW-Madison.

1. Record Holders: The Sleep Cohort Study researchers and their staff.

2. Researchers and others: UW-Madison Research and Regulatory Oversight Boards.

D. How long will my permission last?

This Authorization does not have an end date. You can end this Authorization at any time, however, by withdrawing your permission in writing. Beginning on the date your permission ends, no new health information will be used. Any health information that was shared before you withdrew your permission will continue to be used. After this Authorization ends, you can no longer actively take part in this research study.

Withdrawal of your permission should be made in writing to the person whose name is listed here:

Terry Young, Ph.D.
Sleep Cohort Study
502 N. Walnut St.
Madison, WI 53726-2335

E. Is my permission voluntary?

Your permission is voluntary. You do not have to sign this Authorization form and you may refuse to do so. Your health care providers must continue to provide you with health care services even if you refuse to sign this Authorization form. If you refuse to 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. Federal privacy laws may not apply, however, to some people outside of UW who can share your health information without your permission. If you signed a consent form to take part in this research, more information about confidentiality protections may be found there.

G. Additional information.

You should take as much time as you need to make your decision about giving permission for the use of your health information for this research study. Please ask any questions you have about this Authorization form.

<u>Certification</u>: I have read this Authorization form describing how my health information will be used. I have had a chance to ask questions about the use of my health information and I have received answers to my questions. I agree to the use of my health information for this research study.

Signature of individual or personal representative:

_____ **Date:** _____

****YOU SHOULD RECEIVE A COPY OF THIS FORM AFTER SIGNING IT****

Signature of person obtaining Authorization:

_____ **Date:** _____