Department of Veterans Affairs

Revocation of Authorization for Use & Release of Individually Identifiable Health Information for Veterans Health Administration (VHA) Research

Subject Name (Last, First, Middle Initial)**:**

Subject Social Security Number (last 4 numbers only)**:**

VA Facility (Name and Address)**:**

VA New Jersey Healthcare System (Mail Stop 129) 385 Tremont Ave. East Orange, NJ 07018

VA Principal Investigator (PI)**:**	**PI Contact Information:**
Lisa McAndrew, PhD	862-400-3317

Study Title:

Health Coaching for Chronic Multi-symptom Illness (CMI)

REVOCATION OF AUTHORIZATION:

Your revocation of your authorization must be in writing. You may want to use this form to revoke your authorization as developed for your convenience.

1. I am requesting to discontinue my participation in the research study noted above.

2. I understand the research team may continue to use my information that it has already collected prior to my revocation in order to maintain the integrity or reliability of the research and to the extent that VHA has already acted based on the authorization.

3. I understand that withdrawing from this study does not change my relationship with my health care providers, my future care, or have any effect on my VA benefits.

4. I understand that the research team may need to use my information in order to notify me or government agencies of any health or safety concerns that were identified as part of my study participation.

Research Subject Signature. This revocation has been explained to me and I hereby revoke my research study authorization.

Signature of Research Subject — Date

Signature of Legal Representative (if applicable) — Date

To Sign for Research Subject (Authority to sign: e.g. Health Care Power of Attorney, Legal Guardian appointment, or Next of Kin if authorized by State law)

Name of Legal Representative (please print) — Date