NewYork-Presbyterian
The University Hospital of Columbia and Cornell

Get Involved in Stroke Rehabilitation Research
Sign up for the Stroke Registry!

What is the stroke research registry?
The stroke research registry contains the names of people who have had a stroke and would like to be informed about the research studies at NewYork-Presbyterian Hospital. By putting your name in our registry, you may be able to participate in one or more of our projects. This may include projects done at either of our campuses; Weill Cornell or Columbia Presbyterian Medical Center.

What personal information needs to be kept in the database?
Your name, telephone number, address, date of birth, date of your stroke, and general clinical information. After speaking with you, we will ask your permission to add additional information about your symptoms. This will help us decide which studies you may qualify for.

Why do you want to know my date of birth and the date of my stroke?
By knowing your age and the date of your stroke, we will be better able to determine which, if any, of our studies you may be eligible to participate in.

Who will have access to my information?
Only researchers participating in NewYork-Presbyterian approved stroke research studies will have access to the information in the database.

Who do I contact if I have questions?
Call the Weill Cornell Rehab Medicine Department, Stroke Research office (212) 746-1356.

How do I sign up?
Print and fill out the stroke registry form below and sign and date the HIPAA authorization form on the next page. The last step is to mail both forms back to us at:

NewYork-Presbyterian Hospital
Rehabilitation Medicine
Grace Kim MS, OTR/L
525 East 68th St, Box 142
NY, NY 10065

Please fill out:

☐ Yes, I am interested in being contacted about future stroke research studies.				
Name:		Today's Date:		
Phone:				
Email:				
Address:				
Date of birth:				
Date of your stroke:				
Do you have arm weakness?	☐	Yes	☐	No
Do you have leg weakness?	☐	Yes	☐	No
Do you have visual problems?	☐	Yes	☐	No
Do you have speech difficulty?	☐	Yes	☐	No

HIPAA Form A

HIPAA Clinical Research Authorization for Non-Sponsored Research

Protocol Number: IRB-AAAD6996
Name of Study: The NewYork-Presbyterian Hospital Stroke Registry
Principal Investigator: Joel Stein

For the purpose of the conduct of the above name study, I agree to permit Columbia University Medical Center, my doctors, and my other health care providers (together "Providers"), and Joel Stein and his/her staff (together "Researchers"), to use and disclose health information about me as described below.

1. **The health information that may be used and disclosed includes:**
   - all information collected during the research described in the Informed Consent Form for the above-named study ("the Research"); and
   - health information in my medical records that is relevant to the Research.
   - This may include medical history information that may be considered sensitive, including:

     medical diagnosis of stroke, demographic information (phone/email, age), clinical information related to stroke (side of weakness, presence of motor/visual/ cognitive deficits)

2. **The providers may disclose health information in my medical records to:**
   - the Researchers; and
   - representatives of government agencies, review boards, and other persons who watch over the safety, effectiveness, and conduct of research.

3. **The researchers may use and share my health information:**
   - among themselves and with other participating researchers to conduct the Research;
   - representatives of government agencies, review boards, and other persons who watch over the safety, effectiveness, and conduct of research; and
   - as permitted by the Informed Consent Form.

4. **Please note that:**
   - You do not have to sign this Authorization, but if you do not, you may not participate in the Research.
   - You may change your mind and revoke (take back) this Authorization at any time and for any reason. To revoke this Authorization, you must write to Privacy Officer, Columbia University, 601 West 168th Street, Apt. 22, New York, N.Y. 10032. However, if you revoke this Authorization, you will not be allowed to continue taking part in the Research. Also, even if you revoke this Authorization, the Researchers may continue to use and disclose the information they have already collected as permitted by the Informed Consent Form.
   - While the Research is in progress, you may not be allowed to see your health information that is created or collected by Columbia University in the course of

the Research. After the Research is finished, however, you may be allowed to see this information.

5. This Authorization does not have an expiration (ending) date.

6. You will be given a copy of this Authorization after you have signed it.

Printed Name of Subject: _____

Signature of Subject or Legal Representative: _____ Date: _____

Relationship of Legal Representative to Subject (if applicable): _____