**Directions for use of this template:**

1. Save this template to your computer.
2. Insert information specific for your study where the form says to “insert.”
3. Delete all parentheses, and text that does not apply to your study.
4. Delete these directions
5. Submit the ad text to IRB-HSR for approval.

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Dear x,

The UVA Health System Department of (*insert*) is conducting a research study about *(insert*).

*Insert how you obtained contact information:*

* You are receiving this email because you/your infant/your young child were/was seen in our department for (insert). It is a goal in our department to keep our patients informed of research in which they may be interested while carefully protecting your confidentiality. To do both we follow federal regulation called HIPAA.
* You are receiving this email because you/your infant/your child were/was seen at the UVA Health System for x. UVA feels it is important to inform patients of research projects in which they may be interested while protecting their privacy. For this reason we follow federal regulations called HIPAA which allow the UVA Health System to release your information to researchers at UVA, so that we may contact you regarding studies you may be interested in participating. We want to assure you that we will keep your information confidential.

**USE THIS STATEMENT ONLY IF YOU HAVE OBTAINED PERMISSION FROM THE POTENTIAL SUBJECT’S UVA PHYSICIAN:** Your doctor, Dr. ***insert name*** wanted you to be aware of this research study and gave us permission to contact you.

The purpose of this research study is to (*insert a description in lay language)*.

If you agree to participate/agree to allow your infant/your child to participate, this study will involve completing the survey (*add as necessary)* and the attached Stand Alone HIPAA Authorization *(if the survey collects HIPAA identifiers and PHI*).

Insert risks and benefits

You do not have to be in this study/allow your infant/your child to be in this study if you do not want to participate/allow your infant or child to participate. Your decision to be in any study/allow your infant or child to be in this study is totally voluntary. Your care/Your infant’s care/Your child’s care at UVA will not be altered by your decision to participate or not participate/by your decision to allow your infant/child to participate or not participate.

If you have questions and would like to know more about participation, please contact:

* (*insert contact information*)

Thank you for your time,

*Signature of sender*

*(insert name of sender)*

*(title of sender)*

Principal Investigator: *Insert name*

Study Title: (*insert title)*

IRB-HSR *# : (insert)*