



Medical Monitoring Project (MMP) Statement of Informed Consent

TELEPHONE INTERVIEW



Why we are doing this project

The HIV Program of the Oregon State Public Health Department, together with the Centers for Disease Control and Prevention (CDC), is doing this project to learn more about people who are living with HIV and the types of services they use and need. What we learn from this project may help us improve programs and services that keep people healthy and prevent other people from getting HIV.



What we will need from you

If you choose to be in this project, we will

- ask you questions
- look at your medical records

The questions

Answering the questions will take about an hour. You do not have to answer any question you do not want to answer.

The questions will ask about your

- health
- use of medical and social services
- sexual history
- use of drugs and alcohol
- ability to work and take care of yourself
- reproductive history

Your medical records

We will look at your medical record to collect information about medical care you have received for HIV, lab tests done, illnesses you have had, and medicines you have taken.



What you can expect from us

Privacy



We will protect your privacy. Your answers and medical information will be kept private, confidential, and secure. State and federal laws protect the confidentiality of information kept at Oregon State Public Health and at CDC. Your records will be kept confidential as much as the law allows.

The only time staff will have to report information is if we hear about any of these things happening:

- Abuse of elderly people.
- Abuse of mentally ill or developmentally disabled people.
- Child abuse, which includes physical, emotional, and sexual abuse, neglect, seeing domestic violence, and making or using illegal drugs around a child. This includes events that may have happened many years ago. Child abuse does not include using drugs or alcohol during pregnancy unless it has injured a child.
- That you are an immediate danger to yourself or other people, such as intending to take your own life or someone else's life.

Your name will not be kept with your answers and medical information. Only an ID number will be used to label all the materials connected to you. Only project staff will have access to your answers and medical information.

Using your ID number, we will send some of your answers and medical information to the CDC, so they can better understand HIV medical care and services on a national level. We will not send CDC your name or any information that could identify you.

Reports on this project will not use your name. The information we collect from you will be grouped together with other people's responses so that no one will know which answers came from you.

Token of appreciation

You will receive a \$75 gift card as a thank you for answering the questions and allowing us to review your medical records.



Things to consider

- Some of the questions we ask may make you feel uncomfortable or may seem very personal. Please remember that you do not have to answer any questions you do not want to answer.
- If you would like, we can give you information about where to get medical and social services in your area.
- If you would like, we can give you information about how to avoid giving HIV to someone else.
- Although you will gain no direct benefits from taking part in this project, the information you provide might help us improve the services for people living with HIV and AIDS.

Things to Remember

You have been selected to be in this project because you have HIV. This project is intended to help the Public Health Department learn more about people living with HIV and the types of services they use and need. Taking part in this project is your choice. Refusing to take part or withdrawing from this project will not affect your medical care, nor any services or benefits you are entitled to receive.

Questions?

About this project, please

- Ask the person who asks you the interview questions
- Call the State Public Health project line at 1-800-979-4151

About your rights as a participant, please contact

- **CDC at 1-404-639-6475.** Please leave a brief message letting us know the best way to reach you. Say that you are calling about the **Medical Monitoring Project**. Someone will return your call as soon as possible.

Participant's Consent Statement

I agree to take part in the project described here. I have been read this statement, I understand this statement, and all my questions have been answered. I understand that taking part in this project is completely voluntary.

Verbal Consent Given

Name of Participant

Date

Signature of Interviewer

Date