DESCRIPTION: You are invited to participate in an online pre-screening survey to see if you meet the eligibility criteria for taking part in a research study that will help us develop better medication management strategy for people with chronic pain. We would like to better understand factors influencing the use of pain medications. You will be asked to complete an online survey about your medication use as well as physical, social, and psychological health status.

TIME INVOLVEMENT: You will be asked to complete an online survey, which will take 5-10 minutes to complete.

RISKS AND BENEFITS: There is a small risk that people outside our research lab could learn this information, but we do our best to keep all your information confidential. We also obtained a certificate of confidentiality, which allows us not to disclose information that may identify you in any federal, state, or local civil, criminal, administrative, legislative, or other action, suit, or proceeding, or be used as evidence, for example, if there is a court subpoena, unless you have consented for this use. You should understand that a Certificate of Confidentiality does not prevent you from voluntarily releasing information about yourself or your involvement in this research. If you want your research information released to an insurer, medical care provider, or any other person not connected with the research, you must provide consent to allow the researchers to release it. You may feel uncomfortable answering some questions on the screening survey.

The benefits which may reasonably be expected to result from this study are that we may have better understand challenges that patients face in taking pain medications safely. Subsequently, your information may help us to develop safe medication management. We cannot and do not guarantee or promise that you will receive any benefits from this study. Your decision whether or not to participate in this study will not affect your medical care.

PAYMENTS: You will not be paid for this online survey, but you will have the chance to participate in an additional laboratory study, which will compensate your time up to $100.

PARTICIPANT'S RIGHTS: If you have read this form and have decided to participate in this project, please understand your participation is voluntary and you have the right to withdraw your consent or discontinue participation at any time without penalty or loss of benefits to which you are otherwise entitled. The alternative is not to participate. You have the right to refuse to answer particular questions. Your individual privacy will be maintained in all published and written data resulting from the study. Identifiers might be removed from identifiable private information and, after such removal, the information could be used for future research studies or distributed to another investigator for future research studies without additional informed consent from you.
Authorization To Use Your Health Information For Research Purposes

Because information about you and your health is personal and private, it generally cannot be used for research purposes without your authorization. By consenting to participate in this research study by following the instructions at the end of this form, you are providing your authorization. The form is intended to inform you about how your health information will be used or disclosed in the study. Your information will only be used in accordance with this authorization form and the informed consent form and as required or allowed by law. Please read it carefully before indicating your consent.

What is the purpose of this research study and how will my health information be utilized in the study?
The purpose of this research study is to understand factors influencing pain medication use. Your health information, including but not limited to, your responses to the online surveys could be utilized in this study.

Do I have to provide my authorization?
You do not have to provide your authorization. But if you do not, you will not be able to participate in this and additional laboratory research study. Agreeing to this will not impact your clinical care.

If I provide my authorization, can I revoke it or withdraw from the research later?
If you decide to participate, you are free to withdraw your authorization regarding the use and disclosure of your health information (and to discontinue any other participation in the study) at any time. After any revocation, your health information will no longer be used or disclosed in the study, except to the extent that the law allows us to continue using your information (e.g., necessary to maintain integrity of research). If you wish to revoke your authorization for the research use or disclosure of your health information in this study, you must write to: Dr. Dokyoung Sophia You, PhD, 1070 Arastradero Road, Suite 200, Palo Alto, CA 94304.

What Personal Information Will Be Obtained, Used or Disclosed?
Your health information related to this study, may be used or disclosed in connection with this research study, including, but not limited to, your name, contact information, date of birth, demographics, information about your pain, relevant medical history, treatment and medication information, and your responses to the survey. We do not collect your IP address so your data will NOT be linked to your IP address.

Who May Use or Disclose the Information?
The following parties are authorized to use and/or disclose your health information in connection with this research study:

- The Protocol Director: Dokyoung Sophia You, PhD.
- The Stanford University Administrative Panel on Human Subjects in Medical Research and any other unit of Stanford University as necessary
- Research Staff

File:TEM02C08 rev6 09012016 2 of 3
Who May Receive or Use the Information?
The parties listed in the preceding paragraph may disclose your health information to the following persons and organizations for their use in connection with this research study:
- The Office for Human Research Protections in the U.S. Department of Health and Human Services

Your information may be re-disclosed by the recipients described above, if they are not required by law to protect the privacy of the information.

When will my authorization expire?
Your authorization for the use and/or disclosure of your health information will end on December 31, 2060 or when the research project ends, whichever is earlier.

CONTACT INFORMATION:
Questions: If you have any questions, concerns or complaints about this research, its procedures, risks and benefits, contact the Protocol Director, Dokyoung Sophia You, PhD, at (650) 736-1847.

Independent Contact: Participant’s rights questions, contact 1-866-680-2906. If you are not satisfied with how this study is being conducted, or if you have any concerns, complaints, or general questions about the research or your rights as a participant, please contact the Stanford Institutional Review Board (IRB) to speak to someone independent of the research team at 650-723-5244 or toll free at 1-866-680-2906. You can also write to the Stanford IRB, Stanford University, 3000 El Camino Real, Five Palo Alto Square, 4th Floor, Palo Alto, CA 94306.

Please print a copy of this page for your records.

If you agree to participate in this research, please complete the survey.