

**Authorization and Consent to Release Protected Health Information for
Patients Enrolled as Human Subjects of Research**

Background: The conduct of human research in clinical trials by nature requires access to the medical records of person enrolled in such research. The purpose of allowing such access is to provide Investigators (study Doctors) and the sponsors of the studies information that will verify details of your past medical history as well as current medical conditions. This information is vital in determining the safety and effectiveness of the medications or devices being studied. The study doctor is directed by law to inform you of the extent to which confidentiality of these records will be maintained in the Informed Consent Document that was presented to you.

Consent to Release Medical Information: The Center for Clinical Research believes that in addition to providing informed consent to participate in a clinical trial as a human subject, you should also provide consent to allow those involved in the conduct of the study to examine your medical records that are kept at the below listed hospital and or doctor office:

This includes records compiled in the years before you enrolled in this clinical study and any records that will be compiled until the study is complete. This may include review of records for months or even years after you complete the study so that Investigators may measure the long-term safety of the study medication or device:

Please Document Your Consent Below:

I hereby authorize:

1. North Carolina Baptist Medical Center
2. Forsyth Medical Center
3. Medical Park Hospital
4. Advanced Interventional Pain Management (AIPM)
5. Other Health Care Providers: _____

_____ to release the medical health records of:

Full Name _____; Hospital Number _____;
DOB: _____; SSN# _____ relative to my participation in the study:

These records may include information from the following periods:

- All records Records from ____/____/____ to ____/____/____

My consent to release my medical information will expire on: ____/____/____

I authorize representatives of The Center for Clinical Research, the Sponsor, Forsyth Medical Center Institutional Review Board, the FDA or other federal regulatory agencies to examine and copy these records as needed during the conduct of this study.

I also understand that this consent is subject to revocation at any time except to the extent that action has been taken in reliance upon such consent.

Patient or Representative

Date

Relationship to Patient

Witness

Date