Authorization for Release of Medical Records

Name: _____
Last First Middle/Maiden

Social Security Number: _____ Date of Birth: _____

Request for Release of Information: I request and authorize my health care provider _____ _____ *(insert name and address of the institution from which you are requesting medical records)* to release my medical records (as described below to the _____ *(insert sponsor name and study number)* investigators and their study staff. The purpose this authorization is to allow my medical records to be used in the _____ study, an Institutional Review Bo (IRB) approved research study being conducted by The Center for Clinical Research, of which I am a participant. My records should be sent to the attention of _____ 145 Kimel Park Drive, Suite 330, Winston-Salem, NC 27103 *(insert name and address of the individual who should receive the information)* for use in conducting the research study.

Medical Records To Be Disclosed: This authorization permits _____ *(insert name o provider/institution from which you are requesting medical records)* to disclose the following medical records: *(check one)*

- ☐ All of my medical records that the provider has in his or her possession, including information relating to any medical history, mental or physical condition, and any treatment received by me. This information may include medical information related to treatment of alcohol, substance abuse, HIV/AIDS, and/or psychiatric care or psychological assessments, if applicable.
- ☐ All of my health information described above except for the following: *(list information that is not needed by study personnel)* _____
- ☐ Only the following records or types of health information: _____ *(insert dates of treatment, types o treatment, or other designation)*

Limits of this Authorization: I understand that my medical records/health information will be used and shared with others to carry out this research study and as required by law. I understand that while every effort will be made to protect this informatic absolute privacy and confidentiality cannot be guaranteed. I further understand that if the person or entity receiving this information is not covered by federal privacy regulations, the information may be redisclosed and will no longer protected by these regulations.

Term of this Authorization: This authorization will remain in effect until the end of the _____ study and I will not be able to obtain my research records until then.

Refusal to sign/Right to Revocation: I understand that I may refuse to sign this Authorization for any reason and that such refusal will/will not *(choose one)* affect my eligibility to participate in this research study. In addition, I may change my mind and revoke (e.g., withdrawal or cancel) this authorization at any time by writing the Principal Investigator of the study. This letter can be sent to Dr. Richard Rauck, The Center for Clinical Research, 145 Kimel Park Drive, Suite 330, Winston-Salem, N 27103. However, I understand that even if I revoke this authorization, my health information and medical records already obtained by the _____ study may still be used and shared as necessary to maintain the integrity of the research study.

Questions: I may contact the Principal Investigator named above for answers to my questions about the privacy of my health information. He/she can be reached at 336-765-6181.

_____
Signature Date

If the participant is unable to sign this Authorization, I am the Legally Authorized Representative and have the authority to sign this form.

_____ _____ _____
Name Legal Relationship Date