OMR Oviedo Medical Research

Authorization For Release Of Confidential Information

I, ____, hereby authorize to release all Protected Health Information (PHI) including medical, psychiatric, drug or alcohol abuse, HIV testing, ARC, AIDS information, or for care paid for out of pocket, or any other records of a sensitive nature:

From:	To:
__________________________________ (Name of medical provider)	**Oviedo Medical Research, LLC**
__________________________________ (Address)	2441 West State Road 426, Ste 2011 Oviedo, FL 32765
__________________________________ (Address/ Phone/ Fax #)	Phone: (407) 977-2705 Fax: (407) 359-5420

To expedite the processing of incoming medical records, please FAX all records to us at (407) 359-5420.

My records are to be released for the purpose of: Participation in a Medical Research Study

Send records From: ____________________ (date) To: ____________________ (date)

Records being requested include:

☐ Medical Care Summary
☐ Medication List
☐ Radiology Reports
☐ Visit Notes from the last two medical visits
☐ Laboratory Reports
☐ Hospital Records
☐ Any other records or test results as specified below:
☐ Specialist Consults & Reports

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When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.
I understand that this consent is revocable upon written notice to Oviedo Medical Research, LLC except to the extent that action has already been taken on this authorization.
My written revocation must be submitted to Oviedo Medical Research, LLC's Privacy Officer at *2441 W. State Rd 426, Suite 2011, Oviedo, Florida 32765*.

This authorization shall remain valid for the duration of my participation in the particular Oviedo Medical Research, LLC medical research study for which these records were intended, but this authorization expires 30 days after I am no longer participating in this study.

In accordance with Federal and State regulations, information pertaining to drug or alcohol abuse, HIV testing, ARC, AIDS, or care paid for out of pocket is prohibited from further disclosure to other parties without written consent from the patient. A general authorization for "Release of Information" by another party is not sufficient for this purpose.

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____________________ (Date of Authorization)
________________________________ (Patient's Signature in Full)
____________________ (Patient's Date of Birth)

________________________________ (Witness)
________________________________ (Parent, Legal Guardian or Authorized Representative)