Oviedo Medical Research

Authorization for Release of Confidential Information

I, (printed name)_____ , 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:

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

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 and Continuity of Care

Send records **From:** _____ (date) **To:** _____ (date) ☐ **All**

Records being requested include:

☐ Medical Care Summary
☐ Visit Notes from the last two medical visits
☐ *Any other records or test results as specified below:*
☐ Medication List
☐ Laboratory Reports
☐ Radiology Reports
☐ Hospital Records
☐ 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 research study for which these records were intended and 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.

(Date of Authorization)	(Patient's Signature in Full)	(Patient's Date of Birth)
(Witness)	(Parent, Legal Guardian or Authorized Representative)	

FOR OFFICE USE ONLY

☐ Form Faxed 1st Request – Date: _____ 2nd Request – Date: _____ 3rd Request – Date: _____	☐ Form Mailed 1st Request – Date: _____ 2nd Request – Date: _____ 3rd Request – Date: _____

REGISTRATION INFORMATION

For purposes of patient stipend delivery and coordination of care.

PLEASE PRINT CLEARLY AND COMPLETE ALL SECTIONS		
Last name:	First name:	MI:
Street Address:		
City:	State:	Zip Code:
Date of Birth:	Age:	Gender: ☐ Male ☐ Female
Email 1:	Email 2:	
Phone 1: _____ ☐ Cell ☐ Home ☐ Work ☐ Allow sending text	Phone 2: _____ ☐ Cell ☐ Home ☐ Work ☐ Allow sending text	Phone 3: _____ ☐ Cell ☐ Home ☐ Work ☐ Allow sending text

DEMOGRAPHICS		
Race ☐ Caucasian ☐ Black/African American ☐ Asian ☐ Native American/Alaska native ☐ Native Hawaiian/other Pacific Islander ☐ Other	**Ethnicity** ☐ Hispanic/Latino ☐ Non-Hispanic/Latino	**Marital status:** ☐ Married ☐ Single ☐ Divorced Native language:

EMERGENCY CONTACT INFORMATION		
Primary contact name:		Relationship:
Main phone # ☐ Allow sending text	Alternate phone # ☐ Allow sending text	Email:
Secondary contact name:		Relationship:
Main phone # ☐ Allow sending text	Alternate phone # ☐ Allow sending text	Email:

PHYSICIAN CONTACT INFORMATION		
Physician's name:		
Street Address:		
City:	State:	Zip Code:
Main phone #	Date of last exam:	May we contact your physician? ☐ Yes ☐ No

METHODS OF CONTACT					
Allowed methods of contact			***Preferred*** methods of contact		
☐ Phone 1	☐ Phone 2	☐ Phone 3	☐ Phone 1	☐ Phone 2	☐ Phone 3
☐ email	☐ Text messaging	☐ Mail	☐ email	☐ Text messaging	☐ Mail

PRIOR STUDY PARTICIPATION

Have you previously participated in other research studies? ☐ No ☐ Yes-date of last participation: _____

I agree, as a guest of Oviedo Medical Research, LLC, to comply with the rights of privacy of any person(s) at the Oviedo Medical Research facility. I further agree not to disclose any information regarding any patient or client, which I may observe while visiting the Oviedo Medical Research facility. I also agree, to notify site staff prior to participating in any other research study during my participation with Oviedo Medical Research. I authorize all medical providers at Oviedo Medical Research to treat me medically in the office or hospital for any illness or injury that I may incur.

_____ Signature of Patient or Responsible Party

_____ Date

Reviewed by (Coordinator initials)_____