

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

Records being requested include:

- | | | |
|--|--|--|
| <input type="checkbox"/> Medical Care Summary | <input type="checkbox"/> Medication List | <input type="checkbox"/> Radiology Reports |
| <input type="checkbox"/> Visit Notes from the last two medical visits | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Hospital Records |
| <input type="checkbox"/> Any other records or test results as specified below: | <input type="checkbox"/> Specialist Consults & Reports | |

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.

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

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