ClinSearch
Clinical Research Specialists

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

This authorization is extended to provide protection for individual rights under Federal Laws, Title 42, Chapter 11, Part II. The following guidelines are agreed upon:

- This document provides consent for release of professional medical information
- This request is limited to the person or agency listed
- The information will not be passed on to anyone else or used for any purpose other than as specified
- This consent can be revoked at anytime. Any information released prior to such a revocation shall not be considered a violation of the right of confidentiality
- The facility, its employees, officers and attending physicians are released from legal responsibility or liability for the release of information requested below to the extent indicated and authorized below to the extent indicated and authorized below
- A copy of this release is as valid as the original

I hereby authorize _____*(Name of your Physician/Institution)* to release the following information from my health record:

Patient Name _____

Date of Birth _____ *SS #* _____

Patient Signature _____*Date* _____

Physician Phone: _____ *Fax:* _____

☐ I request that my **research medical records** (procedure reports & labs) be sent to my family doctor (named above). ***If box is not marked, ClinSearch records will not be sent to your family doctor.***

THE FOLLOWING IS FOR CLINSEARCH USE.

**** NOTE TO MEDICAL RECORDS DEPARTMENT ****
If there is a fee for processing medical records, please contact office before sending.

Please send records from within the last 5 years

1st Attempt _____2nd Attempt _____ 3rd Attempt _____

Coordinator _____