



# ENCORE Research Group

ENCouraging COmmunity Research and Education

## Medical Records Release Form

**Name:**

(First, Middle Initial, Last)

**Today's Date:**

**Date of Birth:**

**Social Security #:**

**Gender:**

Male

Female

**Race:**  White  Black or African American  Asian  Native Hawaiian or Other Pacific Islander  
 American Indian or Alaska Native

**Ethnicity:**  Hispanic/Latino  Non-Hispanic/Latino

**Marital Status:**  Married  Separated  Single  
 Divorced  Widowed

**Street Address:**

**City/State/Zip:**

**Home Phone #:** (     )

**Work Phone #:** (     )

**Cell Phone #:** (     )

**E-Mail Address:**

**May we text you?**  Yes  No

**Emergency Contact Name / Phone # / Relationship:**

**Employer Name/Phone Number:**

**How did you hear about our center?**  Doctor  Facebook  Friend  Health Fair  Mailing  Online Ad  
 Newspaper/ Magazine  Radio  Road Sign  Search Engine  TV  Other \_\_\_\_\_

**Primary Physician Name / Phone #:**

**Do you wish results of research exams to be forwarded to this person(s)?**  Yes  No

**Specialist(s) Physician Name / Phone #:**

**Do you wish results of research exams to be forwarded to this person(s)?**  Yes  No

I authorize the release of my complete health records (Psychiatric information, Communicable diseases, Alcohol/drug abuse treatment); **OR**

I authorize the release of my complete health records with the exception of the following:

Psychiatric information,  Drug and alcohol abuse information,  Communicable diseases (including AIDS/HIV,

Other: \_\_\_\_\_ **The purpose of this request is continuity of care for research trials.**

**Known Allergies:**

**I give authorization to release my medical records to Encore Research Group. I agree that authorization may continue until I revoke it in writing or 10 years from the date of my signature. I have read and understand the attached HIPAA Privacy Rule Authorization Form and have been provided a copy for my records. I also consent to be included in the Encore Research Database. I understand per IRS regulations, Encore Research is obligated to report payments of \$600 or more paid in a single calendar year to me.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## HIPAA PRIVACY RULE AUTHORIZATION

Maintaining the privacy of your medical records has been and will continue to be important to Encore Research Group. Beginning April 14, 2003, new federal government mandated privacy rules for protecting health information (HIPAA Privacy Rules) took effect. This document describes how we will use your Personal Health Information (PHI). By signing this document, you authorize Encore Research Group to use your PHI for research purposes and maintain your records in our database.

During your participation at our center, research doctors and staff will collect or create personal health information about you (for example, medical histories and results of tests, examinations or procedures) and record it on forms and computers. Our doctors and staff keep this personal health information in your medical records. In addition, we may obtain and include in your record information regarding your past, present and/or future physical or mental health conditions including medical records from other physicians and medical institutions. Your records may include personal information (such as social security number, date of birth, etc.) that could be used to identify you.

Under federal law, we cannot disclose your PHI without your permission. This permission is called an "Authorization". Because research involves sharing information with other parties, you may not participate in studies unless you provide authorization to disclose your PHI. Your signature indicates that you are agreeing to allow our doctors and staff to use your PHI to conduct studies, monitor health status, and possibly to develop new tests, procedures and commercial products.

Your signature indicates that you are also agreeing to allow the study doctor to disclose PHI to:

- Sponsors of studies and any of the agents, representatives or consultants working on their behalf who help us to conduct studies (referred to as "the sponsor"). The sponsor may analyze and evaluate PHI and may disclose it to the United States Food and Drug Association ("FDA") or similar regulatory agencies in the United States and/or foreign countries. The study staff will assign a code number and/or letters to your records which means that you will not ordinarily be identified in the records sent to the sponsor. However, the sponsor may look at your complete study records, which could identify you. In addition, the sponsor may visit the study site to oversee the way the study is being conducted and may review your PHI during these visits to make sure information is correct.
- The institutional review board ("IRB"), an ethics committee that oversees research, may access your PHI in relation to its oversight responsibilities.
- Other physicians that are assisting in the conduct of the study (i.e., radiologists, pathologists, etc.).
- Other non-study related care providers such as your primary care physicians. Disclosures to non-study related physicians will only be made with your agreement unless, at the study doctor's discretion, this transfer of information is felt to be in your best interest (such as in emergency situations).

Your identity will remain confidential and, except for the disclosures described above, will not be shared unless such disclosure is required by law. If your PHI is given to the parties listed above and/or to others who are not required to comply with federal law, your PHI will no longer be protected by this law and could possibly be used in ways other than listed here.

You have a right to see and make copies of your PHI. You are agreeing; however, by signing the Encore Research Patient Information Sheet, not to see or copy your PHI until the sponsor has completed all work related to the research study in which you participate. At that time you may ask to see your records. Information that does not affect the study conduct can be copied at the study doctor's discretion.

This Authorization will expire 10 years from date of signature unless and until you revoke (cancel or withdraw) authorization. You have a right to revoke it at any time. If you revoke authorization, your PHI will no longer be used for this study, except to the extent the parties to the research have already taken action based upon your Authorization or need the information to complete analysis of ongoing research. To revoke your Authorization, you must send a written notice to the study doctor's office, stating that you are revoking your Authorization to Use or Disclose PHI. If you revoke this Authorization, you cannot continue participation in a research study.