Preferred Research Partners

Print Patient Name: _____ *DOB:* _____ *SS#:* _____

CONTACT PRIMARY CARE PHYSICIAN

It may be important for Preferred Research Partners, Inc. to contact your physician for you to participate in a research study. In order for Preferred Research Partners, Inc. to contact your physician, signed authorization must be received from you. Without your authorization, we will not contact your physician. Please check one of the boxes below.

☐ **I DO** authorize Preferred Research Partners, Inc. to contact my physician if deemed necessary. I also authorize my personal physician to discuss my medical care and past medical conditions with Preferred Research Partners, Inc. . _____ (pt. initials)

☐ **I DO NOT** authorize Preferred Research Partners, Inc. to contact my physician. _____ (pt. initials)

RECORDS RELEASE TO PREFERRED RESEARCH PARTNERS, INC.

It may be important for Preferred Research Partners, Inc. to receive medical records from your physician for you to participate in a research study. In order for Preferred Research Partners, Inc. to receive medical records from your physician, signed authorization must be received from you. Without your authorization, we will not request medical records from your physician. Please check one of the boxes below.

☐ **I DO** authorize my personal physician to provide my medical records to Preferred Research Partners, Inc. . _____ (pt. initials)

☐ **I DO NOT** authorize my personal physician to provide my medical records to Preferred Research Partners, Inc. . _____ (pt. initials)

RECORDS RELEASE TO PRIMARY CARE PHYSICIAN

It may be important for your physician to receive medical records from Preferred Research Partners, Inc. for you to participate in a research study. In order for your physician to receive medical records from Preferred Research Partners, Inc. , signed authorization must be received from you. Without your authorization, we cannot release medical records to your physician.

☐ **I DO** authorize Preferred Research Partners, Inc. to release my medical records to my personal physician. _____ (pt. initials)

☐ **I DO NOT** authorize Preferred Research Partners, Inc. to release my medical records to my personal physician. _____ (pt.initials)

Your medical records will be kept as confidential as possible within the limitations of state and federal law. Federal Privacy Regulations require that you authorize the release of any health information that may reveal your identity. The persons and entities that you are authorizing to use or disclose your individually identifiable health information may include the study doctor, the study staff, the Institutional Review Board (IRB), the sponsor, the sponsor's representatives, the Food and Drug Administration (FDA) or other regulatory agencies in this country or other countries. In order to analyze the data collected during this research study, all of the health information generated or collected about you during this study may be inspected by the study sponsor or the authorized agents of the sponsor, the FDA, the Department of Health and Human Services (DHHS) agencies, the IRB and governmental agencies in other countries. Because of the need to release information to these parties absolute confidentiality cannot be guaranteed. Once your personal health information is released it may be re-disclosed to an entity not covered by the privacy regulations, at which point your health information will no longer be protected by federal privacy regulations. The results of this research may be presented at meetings or in publications; however, your identity will not be disclosed in those presentations. By signing this authorization form you are authorizing such access to your medical records. You may refuse to sign this authorization and your refusal will not affect your ability to obtain treatment. This authorization will have no expiration date. If you do not cancel this authorization then it will remain in effect indefinitely. You may cancel this authorization at any time by notifying the practice in writing to ***[insert name and address of physician]***. If you do cancel this authorization, any information previously disclosed cannot be withdrawn. Once this authorization is cancelled, the study doctor will no longer use or disclose your records unless the doctor needs to do so in order to preserve the scientific integrity of the study. The person or entities disclosing your health information may be paid to do so.

I UNDERSTAND THAT MY MEDICAL RECORDS MAY CONTAIN INFORMATION THAT INDICATES THAT I HAVE A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT IS NOT LIMITED TO DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA OR THE HUMAN IMMUNODEFICIENCY VIRUS ALSO KNOWN AS ACQUIRED IMMUNE DEFFICIENCY SYNDROME (AIDS).

PRIMARY CARE PHYSICIAN / MEDICAL CENTER:

Physician: _____

Address: _____

City/State/Zip _____

Phone/FAX _____

Preferred Research Partners, Inc.:

Physician: _____

Address: _____

City/State/Zip _____

Phone/FAX _____

The undersigned hereby authorizes the release of the following medical reports as indicated above:

☐ All records _____ (pt. initials)

☐ Specify: _____ _____ (pt. initials)

A photocopy of this authorization shall be the same authority as the original. This authorization shall not expire due to the passage of time.

_____	_____	_____
Participant Signature	Date	Witness Signature
_____	_____	_____
Parent, Guardian or Legal Representative Signature	Date	Relationship to Participant

Revised 02/19/2007