Records Release Form

Patient Name:_____DOB:_____SS#_____

Contact with Physician

¨ **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. _____(initial)

¨ **I DO NOT** authorize Preferred Research Partners, Inc. to contact my physician. _____(initial)

Records Release to Preferred Research Partners, Inc.

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

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

Records Release to Physician

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

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

Review of Privacy Statement

¨ **I HAVE** been given a copy of Preferred Research Partners, Inc.'s privacy statement regarding my medical records. _____(initial)

Physician / Medical Center:

Physician:_____
Address:_____
City/State:_____
Phone/Fax:_____

Pharmacy:

Pharmacy:_____
Address:_____
City/State:_____
Phone/Fax:_____

Preferred Research Partners:

Physician:_____
Address:11219 Financial Centre Parkway Suite 320_____
City/State: Little Rock, Arkansas 72211_____
Phone/Fax: phone: 501-553-9987 / fax: 501-553-9986___

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

¨ **ALL RECORDS** _____(initial)
¨ **SPECIFY:** _____(initial)

_____ _____ _____
Participant Signature **Date** **Witness Signature**

_____ _____ _____
Parent, Guardian or Legal Representative **Date** **Relationship to Patient**

Expiration Date: _____

Privacy Statement:

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 the 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 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 participate in the research trial. You may cancel this authorization at any time by notifying the practice in writing. 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 my be paid to do so.

Expiration Date:_____