MEDICAL RECORDS RELEASE FORM
AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Santé Clinical Research

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Purpose for records: Clinical Research Screening and Trial Participation

Today's Date: ____

Patient Date of Birth: Month ______________ **Day** ______________ **Year** ______________

Patient Name: ____ **(Include Maiden/Married)**

Mailing Address (include city, state, & zip): ______________________________

Patient Primary Ph #: ____________________ **Alternative Ph #:** ____________________

Gender at birth: __________ **Self-reported Ethnicity & Race:** ____________________

HISPANIC NON-HISPANIC Emergency Contact Name: ____________________

Relationship to you: ____________________ **Emergency Contact Ph #:** ____________________

Physician or Medical Facility:

Name: ____

Phone#: ____________________________ Fax#: ____________________

Name: ____

Phone#: ____________________________ Fax#: ____________________

Name: ____

Phone#: ____________________________ Fax#: ____________________

I am requesting copies of the results of my medical records including the following information:

- ☐ All progress notes
- ☐ Last 12 months of progress notes
- ☐ Current Medication
- ☐ All Lab and/or procedural reports
- ☐ All Diagnostic/Imaging reports or findings
- ☐ Medical Conditions List

Notes:

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I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY:

I understand that the information provided under this authorization may include Protected Health Information which could contain diagnosis and treatment information including information pertaining to chronic and/or communicable diseases. I can inspect or copy my records but the research facility may stipulate that the records will not be available until after the study is complete or a designated time-period. This information will be used by site staff and investigators for clinical trial purpose. I understand that the information is to be disclosed is protected by law and that the same information may be re-disclosed by the recipient and may no longer be protected by the same law(s) that applied in the first instance. This authorization may be revoked in writing at any time. This authorization expires on _____ or 5 years from the below signature date, whichever occurs first.

______________________	______________________
Patient Name (Print)	**Patient Signature**
______________________	______________________
Parent/Guardian/LAR (Print)	**Parent/Guardian/LAR Signature**

☐FIRST ATTEMPT	☐SECOND ATTEMPT	☐THIRD ATTEMPT
______________	______________	______________