Medical Release Form

Date:	
To: *Name of Healthcare Provider/Physician/Facility* **Address:**	*To be completed by site*

	To be completed by subject
Patient Name:	
Date of Birth:	
Street Address:	
City:	
State:	
ZIP Code:	

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with my participation in a clinical trial at the site named above.

I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

The following data is within scope of this release: Medical records

(including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, telephone messages, immunization records, diagnostic reports, vital signs, allergies, family history, social history, and records received by other medical providers)

Medical Release Form

I understand the following:

1. **I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.**
    a. **To initiate the revocation process, reach out to the site at [*enter-site-number*] or [*enter-site-email*].**
2. **The information released in response to this authorization may be re-disclosed to other Business Associates.**
3. **My participation in the clinical trial or compensation for my participation in the clinical trial cannot be conditioned on the signing of this authorization.**

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein.

Patient Signature: *(or legally authorized representative)*	
Date:	

Name and Relationship of Legally Authorized Representative to Patient:	
Date:	
Witness Signature:	