



Instructions: Fax to: 843-766-5302 or
Mail to: Medical Research South
1481 Tobias Gadson Blvd., Suite 2
Charleston, SC 29407

If you prefer: You can deliver the form in person to the address above.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

FIRST NAME	MI	LAST NAME
_____	_____	_____
DOB	SSN	
_____	_____	
PHONE (Home)	PHONE (Work)	PHONE (Cell)
_____	_____	_____

Pursuant to 45 C.F.R. § 164.508 of the regulations promulgated under the Health Insurance Portability and Accountability Act ("HIPAA"), I hereby authorize the disclosure of my protected health information as described below. This Authorization is provided to you voluntarily and that once released, the information may no longer be protected by HIPAA. I understand that this Authorization will remain in effect for the duration of the study or for (1) year and that I may revoke this Authorization at any time in writing, except to the extent you have taken actions in reliance on this Authorization.

I am interested in participating in clinical studies with Medical Research South, LLC. To meet eligibility for a clinical study I understand that concerned persons from the study doctor's office as well as persons from Medical Research South, LLC need to review my medical record. My signature authorizes persons from my doctor's office to release my medical record and information as described below to Medical Research South, LLC. In the event that I am hospitalized during my participation in a clinical study, I authorize the attending hospital to release my medical records and protected health information to Medical Research South, LLC

Specific description of information requested:

Any information and/or documentation in your possession, or under your control, relating to my medical care, examinations, treatment, radiology, lab reports, hospitalizations, etc.

Patient Signature

____/____/____
Date

Parent or Legal Guardian Signature (if applicable)

____/____/____
Date