AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

As part of the clinical trials that are being done by Advent Clinical Research Centers through your organization, it is required, by the pharmaceutical sponsor, to obtain a complete copy of each subject's medical record for research purposes. The following information will assist you with this request. The subject's authorization to obtain medical information is at the bottom of this request. Please forward requested information to:

Advent Research
4820 Pinellas Park FL 33781
PH: 727-521-9200
Fax: 727-521-9204

Patient Name_____ DOB _____
Address: _____
Social security_____Phone #_____ Alt. Phone #_____
Dates of Service _____
This authorization will expire on _____. (If no date specified,this authorization shall expire 1 yr after date signed)

Information to be disclosed:

____Complete Med History ____ Office Notes ____Lab Reports
____ Procedure Reports ____ Surgery Records ____ Recent Lab/Xray/Imaging

Check and Initial Below:

___ I DO, ___ I DO NOT authorize the release of information pertaining to specific laboratory tests of HIV infection (Human Immunodeficiency Virus, the causative agent of AIDS), the results of such tests, the diagnosis of Acquired Immune Deficiency Syndrome or AIDS related conditions, and all medical records an clinical information relating thereto. ***(Initials of individual giving authorization)*** **_____**

___ I DO, ___ I DO NOT authorize the release of all information, including but not limited to the medical/clinical record and other information pertaining to any evaluation, treatment and/or hospitalization for mental health or psychiatric conditions. ***(Initials of individual giving authorization)*** **_____**

___ I DO, ___ I DO NOT authorize the release of all information, including but not limited to the medical/clinical record and other information pertaining to any evaluation, treatment and/or hospitalization for drug or alcohol abuse, drug-related and/or alcohol-related treatment. ***(Initials of individual giving authorization)*** **_____**

I understand that the information requested is protected by Federal Privacy Regulations. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider; the released information may no longer be protected by Federal privacy regulations. I understand that I need not sign this authorization to ensure treatment. The authorization shall remain valid for 3 years from the date signed below. This information will be used exclusively for the purpose of research that has been approved by your institution through your W3 and by this Subject for this Research Study alone.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the department or facility listed on the authorization. I understand that the revocation will not apply to information that has already been released in response to this authorization.

_____ Date_____
Advent Representative Signature

_____ Date_____
Signature of Patient or Patient Representative (Relationship if applicable)