REQUEST FOR RELEASE OF MEDICAL INFORMATION

Date: _____

****1.** I authorize _____

_____

_____

(Health Care Provider) to use and disclose the protected health information described below to:

International Clinical Research – US, LLC.
819 E 1st Street, Suite 6
Sanford, Florida 32771
Phone: 407-878-5830
Fax: 407-878-5831

****2.** This authorization for release of information covers the period of healthcare from all past, present, and future periods.

****3.** I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

**4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, or other purposes as I may direct.

**5. This authorization shall be in force and effect until I notify International Clinical Research in writing, at which time this authorization expires.

**6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

**7. I understand that information may be disclosed to the sponsor of the study and any agents representatives or consultants working on behalf of the sponsor.

Patient Name: _____

Patient Address: _____

_____

Date of Birth: _____ **SS#** _____

Patient Signature: _____ **Date:** _____