NEUROPSYCHIATRIC RESEARCH CENTER OF SOUTHWEST FLORIDA

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CONSENT TO RELEASE PROTECTED HEALTH INFORMATION

PATIENT/SUBJECT:_____DOB:_____

I hereby authorize Neuropsychiatric Research Center of Southwest Florida to release/receive information from my confidential record to/from:

Practitioner / Facility:_____

Address:_____

City:_____State:_____Zip Code:_____

Phone #:_____Fax#:_____

To release all the medical records including information regarding HIV (AIDS) testing, psychiatric/psychological (mental health information), alcohol and/or drug abuse information and genetics.

_____Admission & Discharge Summary
_____Specialist Consultation
Type: _____
_____Complete Medical Record
_____History & Physical
_____HIV Results (AIDS Testing)
_____Progress Notes
_____Lab/Radiology/EKG
PET/MRI/CT Brain ☐
____Psychiatric/Psychological
(Mental Health)
_____Telephone Communication
_____Other (please specify)

The purpose of this release of information is: **Subject is participating in a clinical research trial.**

This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. Revocation must be made in writing to the provider/facility releasing the information. The provider/facility will not condition treatment on whether I sign the authorization. I also understand that by signing this form I am hereby releasing all parties involved in this exchange from any liability which may arise as a consequence of this disclosure and may no longer be protected by federal law. This release expires in 2 years unless otherwise indicated.
Expiration Date: _____

This information is being disclosed from records whose confidentiality is protected by law. Any further disclosure is strictly prohibited by law.

Subject's Signature: _____Date:_____
☐ Legal Representative: If subject incapable of signing, a legally authorized representative may sign and date the form.
Please indicate your legal authority and include documentation of your relationship:
☐Legal Guardian ☐Health Care Surrogate

Witnessed By:_____ Date:_____