Clinical Research Associates of Central Pa.

1616 East Pleasant Valley Blvd.
Altoona, Pa. 16602
Phone (814-940-1212) Fax (814-940-1211)

PATIENT AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, ____DOB: ____________________________
Patient Name

____ SS# ____________________________
Patient Address

____
Patient Address

authorize ____
Name of Physician, Practice, Facility, etc.

to provide: Clinical Research Associates of Central Pa.
1616 East Pleasant Valley Blvd.
Altoona, Pa. 16602 Fax: 814-940-1211

The information to be released is (state specific documents, time period, etc.):
____
____

Purpose or need for the information requested: _____ Continued Care _____ Clinical Trial Participation

I understand this consent is voluntary and that I may revoke this authorization at any time (except to the extent that action based on this consent has already been taken) by written, dated and signed communication. This consent will remain in effect for one year from the date I signed this consent. I also understand that my medical records may include mental health information, drug/alcohol information and/or HIV information.

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I understand I may refuse to sing this authorization. If I refuse, the identified records will not be disclosed / Whether I sign or refuse to sign, my treatment will not be affected.

_______________________________________ ____________________ ________________
Patient/Parent/Legal Guardian Signature Relationship Date

___________________________________ ________________
Witness Signature Date

If signed by other than patient, state relationship and reason for patient's inability to sign:
____

A copy of this authorization has been _____ accepted _____ rejected by the patient/representative.

A photocopy or facsimile of this authorization will be considered valid unless otherwise specified.

Office Use Only:	6/22/15

CONFIDENTIALITY NOTICE

This release may contain confidential or legally privileged information that is intended only for the individual or entity named in the above-noted address. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or reliance upon the contents of this release is strictly prohibited. If you have received this release in error, please reply to the sender, so that we can arrange for proper delivery and then please destroy the release that you received. Thank you.

- (A certified copy is defined as a copy of the original information that has been verified, as indicated by dated signature, as an exact copy having all of the attributes and information as the original.)

Signature of Individual Preparing Certified Copy of Patient's Records:

Signature:________________________________ Date:__________________________