SOUTHEASTERN CLINICAL RESEARCH INSTITUTE

Renal and General Medical Research

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Consent for Release Confidential Information

All portions of this form must be filled out completely to constitute a valid authorization for release of health information under HIPPA privacy regulations. If any field is left blank, authorization will be considered defective.

Please furnish information to above address

Attn: _____ Date: _____

To: _____

_____

_____

Phone: _____ Fax: _____

Please send the following Health Information:

(_) Discharge Summary (_) History and Physical (_) Entire Record

Other (specify): _____

Health Information to be released to the above is to be used/disclosed for the following purpose(s):

(_) Medical Care (_) Research (_) Clinical Research (_) Other: _____

Patient Signature: _____ SSN: _____

Print Name: _____ Date Of Birth: _____

Address: _____