6817 Southpoint Parkway, Ste. 902
Jacksonville, FL 32216

Authorization to Release Protected Healthcare Information

Name _____

Date of Birth _____/_____/_____ Social Security Number _____-_____-_____

I Authorize (Your Doctors Name) _____ to release my entire medical chart to SECR unless otherwise stated below.

Other _____

Doctor's Address _____

_____

_____

Doctor's Phone _____

Doctor's Fax _____

This information is to be used for patient participation in a clinical research study for

_____

I also understand that I have the right to revoke this authorization at any time through written notice, and that the written notice must include (1) patient's name and address, (2) the effective date of this authorization and the names of those authorized by this form to receive the information, (3) a statement that the patient wants to revoke this authorization and the date revocation is signed and signature of the patient or legal guardian. This authorization will expire 6 months from the date signed unless otherwise stated.

I understand and accept the terms of this authorization.

Signed _____ Date _____/_____/_____

Please send the requested information to:

Dr. Suzanne M. Brulte
Southeast Clinical Research, LLC
6817 Southpoint Parkway, Ste. 902
Jacksonville, FL 32216

904-296-3260
904-296-3262 fax