Attachment A
ADM.PHI 240.05

Carolinas HealthCare System
Authorization for Release of Health Information for Purposes of Research

I hereby authorize the use or disclosure of my identifiable health information as described below. I understand that if the organization authorized to receive the information is not an insurance company or health care provider, the released information may no longer be protected by federal privacy regulations

Patient Name: ______________________________ **Date of Birth:** ______________
Last First Middle/Maiden (mm/dd/yyyy)

The following individual / organization is authorized to release the requested health information:
Name: ______________ **Address:** ______________
Telephone Number: ______________

Please note the date(s) of study: From ______________ **To** ______________
Please check the specific information being released (used or disclosed):

- ☐ History and Physical
- ☐ Discharge Summary
- ☐ Consultation Report
- ☐ Operative Report
- ☐ Emergency Room Record
- ☐ Clinic Notes: ______________
- ☐ Progress Notes
- ☐ Radiology / Imaging Reports
- ☐ Laboratory / Pathology Reports
- ☐ Physician Orders
- ☐ Medication Records
- ☐ Immunization Records
- ☐ Psychiatric Evaluation
- ☒ Other (specify): Abstract

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).

This information may be released to and used by the following individual or organization:
Name: Clinical Research of Gastonia **Address:** 1010 X Ray Drive Gastonia NC 28054
Telephone Number: 704-675-7144 Fax 704-671-2322

I understand that I have a right to revoke this authorization at any time by notifying the Medical Record Department of the providing organization in writing. I understand that my revocation could impact my ability to participate or continue participation in a research study. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that authorizing the disclosure of this private health information is voluntary. I can refuse to sign this authorization but I may not be able to participate or continue participation in a research study. I understand that my refusal to sign or revocation will not harm any relations with my doctors or Carolinas HealthCare System. I understand that I may inspect or copy the information to be used or disclosed. **I understand that this authorization will expire at the closure of the study.**

Printed Name: ______________ **Signature:** ______________ **Date:** ______________
(Patient / Authorized Representative) (mm/dd/yyyy)
If Authorized Representative, please indicate relationship to patient:
☐ Spouse ☐ Parent ☐ Other: ______________

FOR CAROLINAS HEALTHCARE SYSTEM USE ONLY

Study Title: ______________

Please attach a copy of the following: ☐ IRB Approval Letter ☐ IRB Waiver Letter ☐ List of patients in above named study **DATE:** ______________	**IRB APPROVAL** ☐ Yes ☐ No — **IRB Waiver of IC** ☐ Yes ☐ No — **IRB Waiver of Authoriz.** ☐ Yes ☐ No **SIGNATURE:** ______________ **IRB Chair or Designee** **PRINT:** ______________

***Informed Consent Form copy should be in medical record or requested from research staff before releasing the medical record.**

☐ Identification verified ☐ Copy of Authorization given to patient **Medical Record #:** ______________

CHS Employee: ______________
Signature / Title / Date