Meris Clinical Research

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CONTACT US:
PHONE: (813) 413-7218
FAX: **(813) 685-7901**

REQUEST FOR RELEASE OF MEDICAL RECORDS:

I hereby authorize: Physician or Facility Name _____,
the use of or disclosure of the named individual's health information as described below:

TREATMENT DURING THE PERIOD FROM _____ TO _____.

Hospital Records and/or Office Records			
Admission H&P		Medical History	
Discharge Summary		Pathology	
Consults and Progress Notes		Procedure/Op Reports	
Medication Records		Mental Health	
Lab Reports		Other	
Radiology Reports		All records for the last year	

- I understand that I have the right to revoke this authorization at any time. I understand that revocation must be given in writing and will not apply to information that has already been released in response to this authorization.
- I understand this information will be used for continuity of patient care or in the case of my demise during a clinical trial, for post-mortem documentation as required by the FDA.
- This authorization will expire ten years from date of signature, continues until the end of treatment, and covers future services.
- I understand that once the above information has been disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
- I understand authorizing the use of disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

PLEASE FAX RECORDS TO 813-685-7901

PATIENT'S NAME _____ DATE OF BIRTH _____

SIGNATURE _____ DATE SIGNED _____