AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, the undersigned, do herby authorize the release of information from the medical record of:

Patient Name _____ Date of Birth _____

From: (Doctor or Medical Facility)

_____
_____
_____
_____
_____
_____

To:

N.J. Amar, M.D.
ATTN: _____
333 Londonderry Dr., Suite 110
Waco, Texas 76712
Phone: (254)751-1144
Fax: (254)751-9922

Please send copies of medical records for the above named patient for the past 2 years or during the period:

From: _____ To: _____

I understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance on it and that in any event, this authorization expires automatically 6 (six) months from the date of signature.

Signature _____ Date _____

Legal Guardian Signature _____ Date _____
(if under 18 years of age or required)

For office use:	Date	Initials	Records Received	Initials
First Fax				
Second Fax				
Phone Call	Contact and Date			
Phone Call Comment: _____				

Subject: Medical Record Confidentiality

I understand that my medical records and other health information will be collected and analyzed to include:

*laboratory and test procedures
*physical exam findings
*questionnaires/ surveys
*any other pertinent information

I further understand this information will be shared with the party (s) involved with the research study.

I understand that I will be identified by my initials and assigned a study number and that all study information will be retained by The Allergy Asthma Research Institute for at least 6 years and indefinitely by the Sponsor.

I understand that all specimens will be identified with a study code, my initials, and possibly my birth date to include:
*laboratory samples
*biopsies
*tissue specimens
*x-rays, ultrasounds, pulmonary function tests, EKG, Holter monitor and other reports.
I understand that personnel from the following entities might have access to my medical records to the authorized research staff.
*any Institutional Review Board
*Sponsor
*any associated Clinical Research Organization
*the Food and Drug Administration

I authorize, securely storing this information for my participation in future research studies.
I also understand that I may revoke this authorization at any time in writing but:
*may not be able to continue in the study
*new information on me may not be gathered, but already gathered information may be used in the study
*information already sent may not be retrieved or destroyed.

_____ _____

Subject Signature Date