

Authorization to Disclose Information that Identifies You for a Research Study

Patient Name (First, Middle, Last)	Patient Date of Birth (MM, DD, YYYY)
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Please Note: All sections should be completed, or this form may be invalid.

Release Information From

Release Information To

	Boler-Parsegghian Center for Rare & Neglected Diseases
	107 Galvin Life Sciences
	Notre Dame, Indiana 46556

Purpose of Release

<input type="checkbox"/> Treatment/Continued Care	<input type="checkbox"/> Personal	<input type="checkbox"/> Legal Purposes
<input type="checkbox"/> Application for Insurance	<input type="checkbox"/> Disability Determination	<input type="checkbox"/> Payment of insurance claim
Other		
If Other, please explain below: _____		

Information To Be Released

(Required – Please check all that apply)

<input type="checkbox"/> Clinic notes	<input type="checkbox"/> Hospital discharge summary	<input type="checkbox"/> Laboratory reports	<input type="checkbox"/> Radiology reports
<input type="checkbox"/> History and physical	<input type="checkbox"/> EKG's	<input type="checkbox"/> Operative reports	<input type="checkbox"/> Radiology images
<input type="checkbox"/> Hospital notes	<input type="checkbox"/> Immunization records	<input type="checkbox"/> Pathology reports	<input type="checkbox"/> Billing information
<input type="checkbox"/> Other			
If Other, please explain below:			
Service dates (optional)		Information needed by (optional)	
From	To		

I understand the information to be released may include records related to behavior and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS, and genetics. This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. Revocation must be made in writing to the provider/facility releasing the information. The provider/facility will not condition treatment on whether I sign the authorization.

Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law.

This authorization will expire one year from the date of signing unless I indicate an earlier date or event here:

Attention: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.

- If the patient is 18 years of age or older**, the patient must sign and date the form.
- If the patient is 18 years of age or older and is incapable of signing**, a legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship:
 - Legal Guardian or Conservator
 - Health Care Agent (Health Care Power of Attorney)
- If the patient is 17 years of age or younger**, the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship:
 - Parent
 - Legal Guardian

Signature (Required)	Date Signed (Required) (MM, DD, YYYY)		
Printed Name of Person Signing (If Not Patient)			
Mailing Address of Patient - Street			
City	State	ZIP Code	Phone