AXIOM CLINICAL RESEARCH
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## Authorization to Release/Request for an Individual's Health Information/Treatment Records

Last Name: _____ First: _____ Middle: _____

Other Names Used: _____ Date of Birth: _____

Address: _____ City: _____ State: _____

Home Phone: (___)_____ Work Phone: (___)_____

I hereby request access to the protected health information in my health record and my treatment record from

(date)_____ to (date) _____ maintained or created by the provider named below to the recipient named below.

- ☐ Most Recent Progress notes ☐ Discharge Summaries
- ☐ Pathology/Lab Reports ☐ Immunization Records
- ☐ X-Ray/Imaging Reports/Films
- ☐ Entire Health Record *(Excludes Psychotherapy Notes)
- ☐ Other: _____
- ☐ Psychotherapy Notes *(if checking ths box, no other boxes may be checked. A separate Authorization to Release/Request for an Individual's Health Information to obtain additional records.)

- ☐ I will Pick up Copies of my records ☐ Mail copies of my records to the individual noted below
- ☐ Fax my records to: (___)_____ ☐ Provide my records in Electronic form to: _____

| **Records From** | **Records To** |
|---|---|
| Name: | Name: Axiom Clinical Research |
| Address: | Address: 2919 W. Swann Ave. Suite 105A Tampa, FL 33609 |
| Phone: | Phone: 813-353-9613 |
| Fax: | Fax: 813-353-9169 |

**Purpose of request ☐ Patient's Request ☐ Dispute, ☐ Referral, ☐ Other: _____**

**I understand:**

1. I may revoke this Authorization at any time by providing my written revocation to the address at the top of this form. My revocation will not apply to information already retained, used, or disclosed in response to this Authorization. Unless sooner revoked, the automatic expiration date of this Authorization will be twelve (12) months from the date of signature.
2. Unless the purpose of this Authorization is to determine payment of a claim or benefits, Axiom Clinical Research may not condition the provision of treatment or payment for my care on the signing this Authorization.
3. Information used or Disclosed under this Authorization may be subject to red-disclosure by the recipient and no longer protected by federal privacy regulations. Treatment.
4. The Information Authorized for release may include records that may indicate the presence of a communicable disease or non-communicable disease.
5. *The information Authorized for release may include the health information and or treatment records related to mental health. Release of mental health records or psychotherapy notes may require consent of the treatment provider or a court order.
6. The information Authorized for release may include drug/alcohol abuse treatment records. This category of medical information/records is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit anyone receiving this information or record from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2. A general authorization of the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. As a result, by signing below, I especially authorize any such records included in my health information to be released.

_____ _____ _____

Signature of Patient, Parent, or Legal Authorized Representative | Relationship to Patient | Date