AUTHORIZATION FOR MEDICAL RECORDS RELEASE

PATIENT INFORMATION				
Patient's last name: First: Middle:				
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:	Home Phone:	Cell Phone :		
P.O. box:	City:	State:	ZIP Code:	

PRIMARY CARE INFORMATION	
Primary Care Physician Name:	
Street Address:	
City:	State:
ZIP Code:	Phone:

The above indentified patient is requesting the following information be made available to:

Oakland Medical Research Center — PERRFERED METHOD: FAX

115 E. Long Lake, Troy, MI 48085 — FAX NUMBER: 248-813-6511

Ph: 248-687-7412 — ATTN: RESEARCH DEPT.

The receiver of the information a(n): Physician Out Patient Research Center

Information to be released: Please Check All Applicable Records to Release

❑ All Medical Records ❑ Diagnostic Test Reports ❑ Hospital admits/discharge ❑ Other: _____

I understand and agree that the patient records released may include: (a) alcohol and drug abuse information protected under the regulation in 42 code of federal regulations, Part 2, if any, (b) psychological and/or social service information, if any, and (c) information about HIV, AIDS, or ARC protected under MCL 333.51.31, or any communicable disease.

This authorization is valid for a maximum of the duration of participation in the trial; including up to a maximum of 90 days after trial completion, or until expressly revoked by the undersigned.

Signature of Patient: _____ Date: _____