Bradley L. Freilich, M.D.

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

This consent to release information about a patient is intended to satisfy the requirements of Kansas, Missouri and Federal Law.

NAME**:** DOB:
ADDRESS:

Phone:
The undersigned, hereby authorize:

_____

_____

_____

To release the following information pertaining to my medical care for the purpose of a clinical trial:

X_Complete Medical Record
X_Procedure Notes
X_Hospital Dictation
X_Radiology
__Other _____
__Partial_____

X_Lab
X_Biopsy Results
X_Progress Notes
X_Letter

Release to:Kansas City Research Institute, the offices of Bradley L. Freilich, MD, and Janay Kissinger, APRN, BC;

FAX 816-361-4430

I understand that my medical record included information pertaining to all aspects of my medical care, including information regarding visits to my physician, Dr. Bradley L. Freilich, including HIV and referrals of consultants. I understand that I have the right to revoke this authorization at any time. This release of records will expire one year after date of signature. I also understand that the information released may no longer be protected by federal privacy regulations once it has been released from the medical facility. I also understand that a photocopy charge will be incurred for all requests except those directed to a physician or health care facility.

_____ _____

Date Patient/Parent/Legal Guardian/Representative signature