Regional
CLINICAL
RESEARCH
Inc.

Record Release Authorization for Participation in a Clinical Trial

Patient Name Phone: Date of Birth:

Address:

I hereby authorize:

Address: **Fax:**

To Provide Medical Information To: **Regional Clinical Research, Inc.**

415 Hooper Road
Endwell, NY 13760
Phone: 607 786-5341
FAX: 607 754-5730

☒ Vaccine History
❑ Other ________________

I understand that:
- This request has been made voluntarily and without coercion.
- If I refuse to sign this form the releasing facility will not condition treatment or benefits.
- My information may be subject to a subsequent re-disclosure to a third party and may not be covered by Federal privacy regulations.
- I may revoke this request in writing at any time however it will not affect any actions prior to the receipt of the written revocation.
- This authorization will expire 1 year after the date of my signature, or at a different specified date or event: Date: ___________ Event: 30 days after study participation ________________________

THIS DOES NOT INDICATE THAT I AM TRANSFERING FROM YOUR CARE.

____ ____________________
Signature of Patient or Guardian **Date**