PATIENT INFORMATION SHEET

Today's Date________________________

Name: First____________________MI________Last_____________________
Male___ Female___

Address____
City____Zip____________

Home Phone (   )_______________________________
Work Phone (   )_______________________________
Cell Phone (   )_________________________________
E-Mail Address:____
***OR** check here if you DO NOT have an E-Mail:___ [FOR STUDY UPDATES!]*

Date of Birth_____________________________________
Social Security #__________________________________

Employer____
Occupation____

If Married, Spouse's Name____
Spouse's Work Phone (   )____

Nearest Relative or Friend Not Living with You_____________________
Relationship______________________________
Address____
City__________________________________State___________Zip_________
Home Phone (   )____________________________________
Work Phone (   )____________________________________

PRIMARY Doctor: Name____
Address____
City______________________State______Zip__________
Telephone (   )______________________________
Permission to inform Primary Care Doctor of your study participation by asking for your medical records? Yes__ No__

Patient's Signature____

QUALITY RESEARCH INC.
303 W. SUNSET #102
SAN ANTONIO, TX 78209

AUTHORIZATION TO RELEASE INFORMATION

Patient: Name ______________________ Date of Birth ______________
Address ______________________ Social Security# ______________
City ______________ State ______ Zip code ______________
Daytime Phone Number ______________________

YOUR Clinic: Information to be released from:
Clinic Name ______________________ Physician Name ______________
Address ______________________________________
City ______________ State ______ Zip code ______________
Phone # ______________ Fax # ______________

Recipient: Information to be released to:
Quality Research Inc.
303 W. Sunset Road #102
San Antonio, TX 78209
(210) 824-5678
Fax: (210) 824-9829

Information to be disclosed: Medical Record Release

Date of Service Requested: PAST 2 YEARS ONLY From ______________ to ______________

- ☐ Clinic Visit / Progress Notes
- ☐ Consultation/Follow-up Reports
- ☐ Special Tests ______________
- ☐ Lab Reports: Date(s) ______________
- ☐ X-Ray Report/Mammography Report
- ☐ Hospital Reports: Date(s) ______________
- ☐ Hospital Admission & Discharge Summary: Date(s) ______________
- ☐ **All the above (including records relating to HIV, alcohol, drug treatment, records relating to communicable disease and/or those marked confidential).**

**Information in your chart that was not originally generated by this clinic will not be released to another facility. Such information must be obtained from the original source.*

Reason for Release:
Clinical Study Participation.:______________ (indicate Protocol # and condition being studied)

Revocation: I understand that I may revoke this consent at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to Health Information Services Department. I understand the revocation will not apply to information that has already been released in response to this authorization. This consent will automatically expire twelve months from the date of my signature. I do not authorize further release to a third party. I understand that once information is released under this authorization, clinic and their employees and my physician(s) cannot prevent the re-disclosure of that information.

Expiration: One year from date of request

Authorization: I authorize the above provider to release the information marked above to the recipient,

______________________ ______________________
Signature of Patient **Date of Patient's Signature**

Version date: 6/2009

This request will be faxed to your facility a maximum of THREE times.

These forms are provided as a sample to subscribers to HIPAAps.com, Inc., and do not constitute legal advice. All forms should be reviewed by competent counsel to ensure that they apply correctly to the laws and regulations in your locale.

Patient Acknowledgement of Receipt
of the
Notice of Privacy Practices

Quality Research Inc.
303 W. Sunset Rd. #102
San Antonio, Texas 78209

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

By signing this document, I acknowledge that you have provided me with a copy of your *Notice of Privacy Practices.* The *Notice of Privacy Practices* contains a more complete description of the uses and disclosures of my health information.

I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound by such restrictions.

Patient Name: ______________________

Signature: ______________________

Relationship to Patient: ______________________

Date: ____________

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