

1st International Clinical Research Centers

Isaac R. Melamed, MD

AUTHORIZATION TO RELEASE OR OBTAIN MEDICAL RECORDS

Date ___ / ___ / ___

I authorize _____

to release information from the medical record of _____

born on _____.

To: 1st Allergy & Clinical Research Center
7286 S. Yosemite Street #180
Centennial CO 80112

Attn: _____

List information to be released:

- Complete Medical File
- Emergency Room Records/Date ___ / ___ / ___
- Inpatient Records/Date ___ / ___ / ___

It is my intent that information furnished is prohibited for any purpose other than the stated above and that the recipient is prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated above.

I understand I may revoke this consent at any time before the information had been released. A copy of this authorization will be accepted as the original.

I release the organization complying with this request of all responsibility for loss of confidentiality by access and/or copies of records released in compliance to this authorization.

Patient Signature: _____

Patients Legal Representative or Proxy: _____

Relationship to Patient: _____

Witness: _____