*Study # _____*

# Authorization to Release Health Information to Scott & Christie and Associates, P.C. for Clinical Research Study

Part One: AUTHORIZATION

I hereby authorize the disclosure of my protected health care information ____ to Scott & Christie and Associates, P.C. as described in this form.

**Disclosing Party (Eye Care Professional)**: _____

**Information.** Please disclose all information required to be included on the pre-screening paperwork for the applicable clinical research study, including any medical records required to be included.

**Purpose.** The purpose of the disclosure is to determine whether I qualify to participate in a clinical research study.

**Expiration.** This authorization will expire at the end of the clinical research study.

Part Two: NOTIFICATION OF YOUR RIGHTS AS A PATIENT (or patient's representative):

1. You have the right to revoke this authorization prior to the above-stated event, except to the extent the Disclosing Party has already taken action in reliance on this authorization. The revocation will not be effective until it has been received by the Privacy Officer. To revoke this authorization, a written revocation must be submitted to Scott & Christie's Privacy Officer at: 105 Brandt Drive, Suite 204 Cranberry Township, PA 16066.
2. Scott & Christie and Associates may condition research-related care on the signing of this authorization; however, your eye care provider may not condition care on the signing of this authorization.
3. You may refuse to sign this Authorization.
4. Information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected by the Federal Privacy Standards.

Sign below indicate that you: (a) agree to release Scott & Christie and Associates and the Disclosing Party and their respective health care providers, officers, and other personnel from any legal responsibility or liability for disclosure of the above described information to the extent indicated and authorized herein; and (b) have read this Authorization and agree with its terms.

_____

**Printed Name** of Patient or Patient's Representative (indicate relationship/authority)

**X**_____

**Signature** of Patient or Patient's Representative

_____

**Date**

*Initial to indicate you have received a signed copy of this form: _____*

The EYE RESEARCH INSTITUTE