AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I, _____ DOB: _____ hereby authorize disclosure and release of my Protected Health Information in specifications listed below.

Authorization Given To:	**Release Records To:**
_____ (Name of Physician or Facility)	*Intrepid Research, LLC* (Name of Physician or Facility)
_____ (Address)	*4421 Eastgate Blvd. Suite 200* (Address)
_____ (City/State/Zip)	*Cincinnati, OH 45245* (City/State/Zip)
_____ (Fax number)	*513-943-8150* (Fax number)

Information to be disclosed/released*:*

☐All medical records ☐Laboratory/pathology records ☐X-ray/radiology records

☐Last History & Physical ☐Medication List

☐Other_____(describe specifically)

This protected health information is being released for the following purposes:

_____
(List specific purposes above.)

This authorization shall be in force and effect until one year after this request has been signed.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Intrepid Research, LLC.

I understand that information released pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Intrepid Research, LLC will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested disclosure.

I understand that I have the right to: Inspect or copy the protected health information to be disclosed as permitted under federal law.

☐ Refuse to sign this authorization.

☐ Receive a signed copy of this authorization.

_____ _____
Signature of Patient or Patient Representative **Date**

_____
Name of Patient or Patient Representative (Please Print)

_____
Description of Patient Representative's Authority