TIMBER LANE
Allergy & Asthma Research, LLC

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: (first, middle, last) _____
Birth Date: _____(mm/dd/yyyy)

Release information from:_____
_____
_____

I hereby authorize and request you to release to: Edward F. Kent, Jr., M.D.
TIMBER LANE ALLERGY & ASTHMA RESEARCH, LLC**,** 54 TIMBER LANE
SOUTH BURLINGTON, VT 05403 Phone: (802) 865-6100, Fax (802) 383 0434

Purpose of Release: _____ Research, ____Treatment and Continued Care,
____Other, Specify_____

Information to be released:
History and Physical ____ ECG's____ Laboratory Reports____ Hospital Notes____
Immunization Records____ Pathology Reports_____ Radiology Reports____
Hospital Discharge Summary____ Clinic Notes____ Operative Reports____ Radiology Images____
Other____Specify_____
_____

I understand the information to be released may include records related to behavior and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS, and genetics. This authorization may be revoked at any time except to the extent the action has been taken in reliance upon it. Revocation must be made in writing to the provider/facility requesting the information. The provider/facility will not condition treatment on whether I sign the authorization. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law. These records may be viewed by the study sponsors and/or their representatives, the FDA (Food and Drug Administration), DHHS (Dept. of Health and Human Services), and the Institutional Review Boards assigned to these studies. All Records will be De-Identified by the recipient prior to copying or submission to any Institution required for Research purposes. This authorization will expire one year from date of signing unless I indicate an other date or event (end of study participation) here: _____

ATTENTION: This is a legal document. Please read carefully. By signing you agree to the terms on this form. If patient is 18 years or older, the patient must sign the form. If the patient is under the age of 18 the parent or Legal Guardian must sign the form.

Signature:_____Date:_____

Printed name of person signing:_____

Relationship to patient: _____ Self, _____ Parent, _____ Legal Guardian

Mailing address of Patient: Street_____

City_____ State _____ Zip_____ Phone: _____