Medical Affiliated Research Center
303 Williams Ave. Suite 511
Huntsville, AL 35801
(256) 533 - 6603

North Alabama Research Center
721 W. Market St. Suite B
Athens, AL 35611
(256) 771 - 9919

Cullman Research Center
909 Graham St. SW Suite D
Cullman, AL 35055
(256) 735 - 4262

Request for Medical Records

Patient Full Name: _____ **Last 4 of SS#:** _____

Date of Birth: _____/_____/_____ **Phone Number:** (_____) _____-_____

I request and authorize _____ to release my healthcare

information to ***New Horizon Research Group, Inc.***

_____ **Medical Affiliated Research Center** _____ **North Alabama Research Center** _____ **Cullman Research Center**

Please initial the appropriate box:

_____ All of my Medical / Dental Records **OR**

_____ Specific Medical / Dental Records: _____

- I authorize the release of any record for drug, alcohol and/or mental health treatment.
  _____ **(Initial)**
- I authorize the release of any record for the testing, reporting, or research pertaining to HIV infection or any sexually transmitted or related disease whether negative or positive.
  _____ **(Initial)**

I understand that I have the right to revoke this authorization at any time. I understand that I must do so in writing and present the writing revocation to New Horizon Research Group, Inc. I understand the revocation will not apply to information that has already been released to this authorization. The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability & Accountability Act Privacy Rule, 45 CFR Part 164, and the Privacy Act of 1974 (5 USC 552a).

Patient Name (PLEASE PRINT): _____

Patient Signature: _____ **Date:** _____/_____/_____