Authorization for Release of Medical Record Information
GuLF STUDY: Gulf Long-term Follow-up Study

Please provide your doctor's contact information. There are copies if you have more than one doctor.

Specialty: ☐ Neurologist ☐ Emergency Medicine Specialist ☐ General Medicine Practitioner ☐ Other

Provider Name: _____

Facility Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: ( ) - _____ Ext: _____ Fax: ( ) - _____

I am participating in the GuLF STUDY, a study of the health effects of the 2010 Deepwater Horizon oil spill. I authorize and request that you provide the GuLF STUDY with copies of my medical records that pertain to my stroke diagnosis. **The study is requesting records from April 1, 2010 to the present date.**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) prohibits you from releasing my information without my authorization. This form gives you my authorization. I understand that my decision to sign or not to sign the form will have no effect on my eligibility for treatment, payment, or enrollment. There may be sensitive information in my medical records. The study may see that information but will not use it.

Once my information is released to the study, it is no longer covered by HIPAA, but is covered by the Public Health Service Act, which prohibits the release of information that would identify me or my medical providers outside the sponsoring agency and its contractors without my permission or that of my medical providers.

I authorize the study to use information I have given to help you identify my records. I can revoke this authorization at any time by contacting a study representative in writing or by telephone at the address and telephone number listed below. I can also revoke this authorization by notifying the health care facility medical records department in writing. I have received a copy of this authorization form.

Patient Name: _____

Patient Signature: _____ **Date:** _____

Other Names under Which Records May be Filed: _____

Patient Date of Birth: ☐☐ ☐☐ ☐☐☐☐
MONTH *DAY* *YEAR*

Proxy Signature: _____ **Date:** _____

Printed Name of Proxy: _____ I am the designated representative for the above-named patient.

Reason for Proxy: ☐ Patient deceased ☐ Patient incapacitated **Relationship to Patient:** _____

<BARCODE>

GULF STUDY OFFICE
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U.S. Department of Health and Human Services • National Institutes of Health • National Institute of Environmental Health Sciences