SOUTHEAST
clinical research LLC
304 NE 1st St. • Chiefland FL 32626 • 352-490-4816 - Phone • 352-490-8852 - Fax

Authorization to Release Protected Healthcare Information

Name _____

Date of Birth ____/____/____ Social Security ____-____-____

I Authorize (Your Doctor's Name) _____ to release my entire medical chart to SECR unless otherwise stated below.
Other _____

Doctor's Address _____
_____
_____
Doctor's Phone _____
Doctor's Fax _____

I understand that I have the right to revoke this authorization at any time through written notice, and that the written notice must include (1) patient's name and address, (2) the effective date of this authorization and the names of those authorized by this form to receive the information, (3)a statement that the patient wants to revoke this authorization and the date revocation is signed and signature of the patient or legal guardian. This authorization will not expire unless otherwise stated.

I understand and accept the terms of this authorization.

Signed _____ Dated ____/____/____

Please send the requested information to:

Southeast Clinical Research, LLC
304 NE 1st Street
Chiefland, FL 32626
352-490-4816
352-490-8852 fax