Authorization for Physician to Release Medical Records

This authorization grants your permission for your healthcare provider to disclose your protected health information to researchers from St. Louis College of Pharmacy. This study has been approved by the Institutional Review Board (IRB) at St. Louis College of Pharmacy. Please read the form in its entirety before signing and complete all the sections that apply.

Specific information to be disclosed:
_X_ Most recent pulmonary function tests or spirometry results

Reason for release of information: Participation in "COPD Severity and Adherence to GOLD Guidelines in the Community Pharmacy Setting".

Patient granting authorization:

Full name: _____
Date of birth: _____
Address: _____City: _____
State: _____Zip Code: _____
Phone (___) _____

Contact information of healthcare providers/health care entity authorized to disclose information:

Physician (Primary care doctor, Internist, or Family Doctor) (Please complete at least name and city)
First Name: _____ Last name_____
Address: _____ City: _____
State: _____ Zip code: _____
Phone: (___) _____ Fax: (___) _____

Physician (Pulmonologist/ lung doctor)
First Name: _____ Last name _____
Address: _____ City: _____
State: _____ Zip code: _____
Phone: (___) _____ Fax: (___) _____

Person receiving information:
Name: Suzanne G. Bollmeier, Pharm.D., BCPS, AE-C
Principal Study Investigator, COPD Severity and Adherence to GOLD Guidelines in the Community Pharmacy Setting
St. Louis College of Pharmacy
4588 Parkview Place
St. Louis, Missouri 63110
Fax: 314.446.8165 (if questions, please call Dr. Bollmeier at 314.446.8525)

Authorization to Release Medical Records **(continued)**

By signing this form, I agree and acknowledge:

Voluntary authorization: This authorization is voluntary. Treatment, payment, enrollment, or eligibility for pharmacy or medical benefits (as applicable) will not be conditioned upon my signing of this authorization form.

Effective time period: This authorization shall constitute a one-time release of information.

Signature authorization
I have read this form. I agree to the use and disclosure of my breathing test results to the study investigators as part of my participation in "COPD Severity and Adherence to GOLD Guidelines in the Community Pharmacy Setting".

Signature:

Patient: _____Date:_____