BLOCK, NATION, CHASE & SMOLEN FAMILY MEDICINE

We believe in paving the way for the future of medicine. The Physicians at Block, Nation, Chase & Smolen Family Medicine often participate in pharmaceutical research trials. There is an opportunity for you, our patients, to participate as well.

What are the benefits to participants?

If you would like to participate in a pharmaceutical medical research study and if you qualify based upon one of your medical conditions (and other criteria, such as coexisting medical problems), then you could receive many benefits. As a participant, our medical care and services for your research study related medical condition would be at no cost to you or your health insurance plan, and you would receive financial compensation for your time & travel to see us; additionally, you would receive medication and testing (such as blood tests or EKG's) without cost to you or your insurance plan for your research study related medical condition. You might also be eligible to receive a new type of medication not yet available at pharmacies, and you will still receive your medical care from the physicians at Block, Nation, Chase & Smolen Family Medicine.

What kinds of medications are being studied?

Many of the medications being researched are already "on the market", but are now being compared to other medications; some medications are not yet "approved" by the FDA for general use by the public, but are in the last phase of testing (through large scale use) in order to seek final FDA approval. At this point of the FDA approval process, these medications have already been through prior phases of required FDA safety testing.

Who Will Be Handling Your Care?

During these pharmaceutical research trials, the physicians at Block, Nation, Chase & Smolen Family Medicine will be working jointly with a full-time nurse from **Oviedo Medical Research, L.L.C.** (or other similar research organization), who will act as our research coordinator. This nurse will be working part time at our office caring for our patients under the supervision of our physicians.

Why am I Receiving This Form to Sign?

The doctors at Block, Nation, Chase & Smolen Family Medicine will identify patients who might be eligible to participate in a pharmaceutical trial based upon their medical conditions. We will then contact patients to discuss their potential interest in participating in the study (as well as more specific details about the study protocol). Most importantly your medical records and personal information are never taken out of our office or shared with any other person or entity outside our practice unless you provide written authorization for us to do so. Thus, because our research nurse is not directly employed by Block, Nation, Chase & Smolen Family Medicine, we cannot allow this nurse to contact you about a research opportunity or review your medical records without your signed approval on this Authorization form.

Authorization for the Use and Disclosure of Medical Record and Individually Identifiable Health Information:

I (the "Patient") hereby authorize the use or disclosure of my medical record and individually identifiable health information as described below for the purpose of pharmaceutical research trials. I understand that the information I am authorizing the persons and entities listed below to receive, disclose, use and review may be re-disclosed as part of an independent clinical research trial and may no longer be protected by federal or state privacy laws and regulations if I choose to participate in (or screen for enrollment in) a pharmaceutical research trial. In most cases all medical record and individually health identifiable information is removed from a patient's file by the research trial before it is re-disclosed for research and review purposes. **But, in ALL cases medical record and individually identifiable health information is never sent to any pharmaceutical company.**

1. Persons/organizations authorized to use, disclose, or review the information:
   Block, Nation, Chase & Smolen Family Medicine and its physicians, staff members, clinical personnel and employees of Oviedo Medical Research, L.L.C. (or other similar research organization).
2. Specific description of information that may be used/disclosed:
   Patient's medical record information including, but not limited to, lab results, diagnostic testing results, progress notes, and clinical research trial information**.** It also includes any HIV/AIDS, mental health, reportable communicable diseases (such as STD's and Hepatitis), and substance abuse treatment information contained in my medical record.
3. The information will be used/disclosed for the following purposes:
   For assessment and evaluation for participation in clinical research trials.
4. I understand that this Authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign or my revocation of this Authorization will not affect my ability to obtain treatment from Block, Nation, Chase & Smolen Family Medicine, receive payment, or eligibility for benefits unless allowed by law.
5. The person/organization authorized to use/review the information will receive compensation for doing so. Yes **X** No____ (But only if you participate in a research trial or go through the screening & testing process of a specific trial; otherwise there is no financial compensation to anyone).
6. I understand that I may inspect or copy the information used or disclosed.
7. I understand that I may revoke this Authorization at any time by notifying the person/organization providing the information in writing, except to the extent that:
   (a)Action has been taken in reliance on this authorization; or
   (b) If this authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.
8. By signing I revoke all authorizations allowing Compass Research to contact me regarding pharmaceutical research trials.

_____ _____

Signature of patient or patient's legal representative | Date

_____ _____

Printed name of patient or patient's legal representative | Relationship to patient or legal authority to act for the patient

*Initial if you prefer to DECLINE this opportunity:*_____

12/2015