**Pt # \_\_\_**

**AUTHORIZATION TO RELEASE PROTECTED HEALTH CARE INFORMATION**

**(HIPAA COMPLIANT)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Telephone: ( ) \_\_\_\_\_\_\_\_\_\_\_

(PRINT NAME OF PATIENT)

**Last 4 digits of Social Security Number:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Information to be released from:** Dr.’s Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*(Patient’s health care provider)* Address: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Records may be released to:** Dr. R. McMahon/Dr. B. Hajjar, Oral Surgery Group, 8691 Connecticut Street, Suite A, Merrillville, IN 46410, Office office/ph: 219-757-5700, Fax: 219-757-5706

Pursuant to the Health Insurance Portability and Accountability Act **(HIPAA**) Privacy Regulations, 45 CFR § 164.508, the provider listed above is hereby authorized to release medical records to the Oral Surgery Group for their research on Osteonecrosis of the Jaw.

**Type of Information:**

1. *Dental and medical records,* including hospital summaries, oral surgery operative records and pathology reports, *as they relate to jaw osteonecrosis or jaw pain*.
2. Include *medications* that have been used /are used in the treatment of osteoporosis/osteopenia, *specifically*: **Actonel/Atelvia** (risedronate), **Boniva** (ibandronate), **Didronel** (etidronate), **Fosamax** (alendronate), **Prolia** (denosumab), **Reclast** (zoledronate), and any others used.
3. If this patient has cancer include all chemotherapy medications, such as:  **Aredia** (pamidronate), **Avastin** (bevacizumab), **Cytoxan** (cyclophosphamide), **Nexavar** (sorafenib), **Rapamune** (sirolimus), **Skelid** (tiludronate), **Sutent** (sunitinib), **Xgeva (**denosumab) **, Zometa** (zoledronate) and any other medications used.
4. Include all *steroid medications* used in treatment of asthma, arthritis, allergic reactions, etc., *specifically*: **Cortef** (hydrocortisone), **Celestone** (betamethasone), **Decadron** (dexamethasone) **, Florinef** (fludrocortisone) , **Medrol** (methylprednisolone), **Prednisone, inhaled steroids, such as Qvar** (beclomethasone), **Azmacort** (triamcinolone), **Aerobid** (flunisolide), **Pulmacort** (budesonide), **Flovent** (fluticasone), **Advair** (salmeterol+fluticasone), or steroids used in injections, such as epidural, knee, articular injection or other steroids.
5. Include the *most recent* Lipid panel blood test with Total Cholesterol, LDL Cholesterol, HDL Cholesterol & Triglyceride blood tests.

A photo copy shall be as valid as the original.

**Patient Signature:** **X \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**

If you are a Guardian or Authorized Representative, please provide documents proving that you have the authority to sign on behalf of the patient.

**Guardian Signature/Authorized Rep:** **X \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**

**AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION RESEARCH**

Initial: \_\_\_\_

In order to participate in this research study, you need to agree to permit the study site you are participating at, your doctors and your other health care providers (together “Provider”) to use and disclose (release) health information about you as described below.

1. The health information that may be used and disclosed includes:

* All information collected during the study described in the Informed Consent Form for the study; and
* Health information in your medical records that is relevant to the study.

1. The Providers may

* Use and share your health information among themselves and with the sponsor of the study, Agendia, Inc., and its agents and contractors (together “Sponsor”); and
* Disclose your health information to representatives of government agencies, review boards, and other persons who watch over the safety, effectiveness and conduct of research.

1. The Sponsor may use and share your health information as permitted by the Informed Consent Form.

Information sent to Agendia as part of your standard of care will have personal identifying information on it, such as your name and date of birth. However, the data that is entered into the clinical database will have the personal identifying information removed and the clinical data will be identified using a secure code. The clinical team at Agendia will not be able to link the code back to your identifying information.

1. Once your health information has been disclosed, federal privacy laws may no longer protect it from further disclosure.

1. Please not that you do not have to sign this Authorization, but if you do not, you m ay not participate in the study. You may change your mind and revoke (take back) this Authorization at any time and for any reason. To revoke this Authorization, you must write to your study doctor at the address listed on page 1 of this document. However, if you revoke this Authorization, you will not be allowed to continue taking part in the study. Also, even if you revoke this Authorization, your Providers and the Sponsor may continue to use and disclose the information they have already collected to protect the integrity of the study or as permitted by the Informed Consent Form.
2. This authorization does not have an expiration (ending) date.
3. You will be given a copy of this Authorization after you have signed it.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of participant Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name of participant

Initial: \_\_\_\_