SUNY DOWNSTATE Medical Center

RESEARCH SUBJECT RECRUITMENT:

PHYSICIAN'S DOCUMENTATION OF PATIENT'S VERBAL AUTHORIZATION

Patient Name: _____ MR#: _____

Address: _____

_____

DOB: _____ Telephone#: _____ (Day) _____ (Eve)

I hereby certify that I have discussed the following information with the patient identified above and that the patient has authorized me to disclose his/her information to the SUNY Downstate Medical Center physician/ principal investigator identified below for the purpose of research recruitment:

1. Physician/ Principal Investigator Name: _____

Department: _____

Research Study/ Protocol: _____

2. Information to be disclosed:

NOTE: This information may NOT include any information regarding mental health, any HIV- related condition (including HIV-related test, illness, AIDS or any information indicating potential exposure to HIV) or drug and alcohol abuse.

3. I informed the patient that s/he is not required to provide this authorization and that his/her healthcare, payment for healthcare and healthcare benefits will not be affected if authorization is not provided.

4. I further informed the patient that this authorization expires at the end of the subject recruitment phase of the research study, unless otherwise stated to me. I also notified the patient that s/he has a right to revoke the authorization if the information was not already disclosed to the physician/ principal investigator named above.

_____ _____ _____

Print Name of Physician Signature of Physician Date