CENTER FOR
BrainHealth
THE UNIVERSITY OF TEXAS AT DALLAS

Research Records Release Authorization

Full Name: _____ Date of Birth: _____

Physical or Mailing Address: _____

Contact Phone Number (s): _____

This will authorize The Center for BrainHealth to use or disclose research records to:

_____

as described below for the following purpose (or write "At the request of the individual"):

_____

_____ Complete copy of research records

_____ Other (describe)

_____

Dates of participation in research includes: _____ to _____

Name of research study or study coordinator: _____

This authorization will expire on _____(date or event). If no other date is listed, expiration is six months from the date it was signed.

Please provide copy to the subject individual (Please mark Yes or No). Yes_____ No_____

X I understand that I may inspect and receive a copy the records described by this authorization. Texas law established nominal fees for copy charges of records.

X I understand that this authorization may be revoked in writing at any time by sending a written notice to the Records Custodian, The Center for BrainHealth at UT Dallas, 2200 West Mockingbird Lane, Dallas, Texas 75235. Written revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.

X I understand that if neither federal nor state privacy law applies to the recipient of the information, I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or state privacy law.

X This Authorization is voluntary and I may refuse to sign this Authorization form.

_____ _____

Date Signature of individual or representative

_____

[Authority or relationship of representative]

Records Custodian at The Center for BrainHealth at UT Dallas
2200 West Mockingbird Lane Dallas, Texas 75235-5451
(214) 905-3007 phone (972) 883-3299 fax