

**Richard N. Marple, M.D.**  
**Medical Director**  
**CASTLEROCK CLINICAL RESEARCH CONSULTANTS, LLC**

**Consent to the Use and Disclosure of Health Information**

I understand that as part of my participation in clinical research trails, Castlerock Clinical Research Consultants, LLC (CCRC) originates and maintains medical and health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment also called Protected Health Information or PHI. I further understand that this information serves as a:

- means of reviewing my medical records for possible inclusion in research protocols
- basis for planning my care and treatment as related to individual research protocols
- means of communication among the agents involved in collection and evaluation of data related to my participation in clinical research trials.
- tool for routine research operations such as assessing safety and efficacy and reviewing the data compiled related to my participation in clinical research protocols

**I further understand and agree that this agreement to release information shall apply to all information accumulated up to this date and to any information acquired in the future. This agreement to release future information shall remain in force until such time as I shall revoke it in writing. I further understand that my PHI cannot be seen or copied for me until all work related to individual clinical research trials has been completed by the sponsor.**

I understand and have been provided with an **AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION** brochure that provides a more complete description of information uses and disclosures. I understand that I have the right to review the **AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION** brochure prior to signing this consent. I understand that CCRC reserves the right to change their notice and practices, but that prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for database purposes.. I understand that I must revoke this consent in writing, except to the extent the organization has already taken action in reliance thereon. I also understand that CCRC may use any information gathered, related to a research protocol for which I have signed prior Informed Consent, and that data hitherto collected may be used to complete said research protocol.

By Oklahoma law we are required to notify you **that the information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).**

In addition to the releases outlined above, information may be released to the following individuals/organizations for the indicated purpose:

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

I request the following restrictions to the use and/or disclosure of my health information: \_\_\_\_\_

You \_\_\_\_ may \_\_\_\_ may not include my demographic data in a research database.

You \_\_\_\_ may \_\_\_\_ may not leave (appointment reminders)(medical information) on my message service or machine.

You \_\_\_\_ may \_\_\_\_ may not fax information to me. My fax number is: \_\_\_\_\_

You \_\_\_\_ may \_\_\_\_ may not contact me by E-mail. My E-mail address is:  
\_\_\_\_\_@\_\_\_\_\_

- I have read and agree to the above Consent
- I have read and agree to information contained in the **AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION**

**SIGNATURES:**

\_\_\_\_\_  
Subject or Legal Representative

\_\_\_\_\_  
Date Notice Effective

\_\_\_\_\_  
CCRC Representative / Title

\_\_\_\_\_  
Date