Olympian Clinical Research

Today's Date:_____

Can we call/email/TEXT you when other studies become available you might qualify for? (*Circle*) Yes No

Can we send you text message appointment reminders? (*Circle*) Yes No

Have you participated in a clinical research study within the last 30 days? (*Circle*) Yes No

First Name | Middle Name | Last Name

Date of Birth | Gender | Email

Race (*Check one*):

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Caucasian or White
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Unknown or Other (*Specify*) _____

Ethnicity (*Check One*):

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Not Willing to Provide

Home Phone | Cell Phone | Work Phone

Ok to Leave Detailed Message? (*Circle*) Yes No On (*Circle*): Home Phone Cell Phone Work Phone

Home Street Address | Apt. #

City | State | Zip Code

Emergency Contact Name | Relationship | Emergency Contact Phone Number

Primary Care Physician's Name | Physician's Phone Number

I certify that the information contained in this medical history is true and complete to the best of my knowledge. I agree to hold harmless and indemnify Olympian Clinical Research and its physicians and staff from any and all liability resulting from incorrect or misleading information that I have provided.

_____ _____

Signature | Date

Olympian Clinical Research

Release of Medical Records

AUTHORIZATION TO RECORDS FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION INCLUDING PSYCHIATRIC/ PSYCHOLOGICAL CONTAINED IN PSYCHOTHERAPY NOTES

Patient Name:_____ DOB:_____ SS#:_____

Patient (Legal Rep Name):_____ by signing this form I understand that I am authorizing the designated medical records custodians or database custodians to use and/or disclosure my protected health information (PHI) as defined under 45 CFR 160-164, the federal regulations implementing the Health Insurance Portability Accountability Act of 1996 ("HIPPAA") as described below to the following person (s) or organization (s):

Release to:
Olympian Clinical Research
2919 Swann Ave.
Suite 205
Tampa, FL 33609
Telephone Number: 813-849-5566
Fax Number: 813-868-3050

I specifically authorize the use and Disclosure of the following PHI:

- Initial Evaluation
- Follow Up Notes
- Psychological Tests
- Verbal Reports
- Clinic/outpatient records
- Laboratory Reports
- Pathology Reports
- Radiology Reports
- Consultation Reports
- Hospitalization Records
- Medication Administration Records

The information to be used or disclosed pursuant to this authorization form may include information relating to psychiatric or psychological care, including psychotherapy session notes as defined in 45 CFR 164, 501. If I am the patient requesting my own psychiatric/psychological treatment records, I understand that I may review a report of examination and treatment instead of copies of the psychiatric/psychological records. "There is potential that the PHI may be re/disclosed by the recipient and no longer protected by federal or state privacy laws."

I may revoke this authorization form at any time by notifying the above-referenced records custodian at the location listed above, of my attempt to revoke this authorization. Returning this form to the records custodian, signed, dated and with the words "authorization revoked" is sufficient notice. However, I understand that such revocation will not have any effect on any information already used or disclosed by Olympian Clinical Research before the clinic received any written notice of revocation.

This authorization form expires one year from the date of the signature below. I may inspect and receive a copy of the information to be used and disclosed pursuant to the authorization form. I understand that I am not required to sign this authorization form in the exchange for the patient receiving treatment from Olympian Clinical Research. I also understand that payment, enrollment in health plan and/or eligibility for benefits will not be continued upon my signing this form. I understand that I may refuse to sign this form.

_____ _____
Signature of patient or personal representative Date

_____ _____
Printed name of patient or personal representative Relationship to patient granting authority to act for patient

_____ _____ _____
Witness Signature Printed Name of Witness Date

The following form is an authorization to share any medical procedure/ lab results. You may elect to share results or not to share results. Your choice does not affect your participation in a study. Please **initial** next to one of the following.

_____ If I choose to participate in a study, I elect to have any test results shared with my Primary Care Physician. (List primary care physician below)

_____

_____ If I choose to participate in a study, I do NOT elect to have any test results shared with my Primary Care Physician.

_____ If I choose to participate in a study, I elect to have any test results shared with another Physician, other than my Primary Care Physician and designate. (List name below)

_____

_____ I do not have a Primary Care Physician to share any test results with.

_____ _____

Signature of patient Date

_____

Printed name of patient

_____ _____

Signature of LAR or Caregiver Date
(Only if applicable)

_____

Printed name of LAR or Caregiver

Medications:

Please list ALL medications you are taking currently or have taken within the **past 90 days**. Include all prescriptions, over the counter medications, vitamins, dietary supplements, weight loss products, and herbal preparations.

Medication and Dose	Indication for Use	Start Date	Stop Date or ongoing

Patient Signature:_____ Date:_____

Please check all past and current PHYSICIAN DIAGNOSED illnesses.

Dermatologic

- ☐ Acne
- ☐ Actinic Keratosis (AKs)
- ☐ Basal Cell Carcinoma
- ☐ Cellulite
- ☐ Squamous Cell Carcinoma
- ☐ Malignant Melanoma
- ☐ Eczema/ Dermatitis
- ☐ Hair Loss
- ☐ Hidradenitis Suppurativa
- ☐ Herpes (Oral or Genital)
- ☐ Psoriasis
- ☐ Psoriatic Arthritis
- ☐ Rosacea
- ☐ Seborrheic Keratosis (SKs)

Neuorologic/Psychiatric

- ☐ Alcohol/ Substance Abuse or Dependence
- ☐ Alzheimer's Disease
- ☐ Anxiety Disorders
- ☐ Attention Deficit Disorder
- ☐ Autism/Pervasive Development Disorder
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Insomnia
- ☐ Memory Loss
- ☐ Migraine
- ☐ Multiple Sclerosis
- ☐ Obsessive Compulsive Disorder (OCD)
- ☐ Parkinson's Disease
- ☐ Post Traumatic Stress Disorder (PTSD)
- ☐ Schizophrenic Disorders
- ☐ Seizure
- ☐ Stroke/ TIA
- ☐ Suicide Attempt
- ☐ Tourette Syndrome

Respiratory

- ☐ Allergies
- ☐ Asthma
- ☐ Bronchitis/ Sinusitis
- ☐ COPD
- ☐ Cystic/Pulmonary Fibrosis
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Sleep Apnea

Musculoskeletal

- ☐ Chronic Pain_____
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Sciatica

Cardiovascular

- ☐ Angina
- ☐ Atrial Fibrillation
- ☐ Cardiac Arrhythmia
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Pacemaker

Infectious Disease

- ☐ HIV/ AIDS
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C

Hematological

- ☐ Anemia
- ☐ Blood Clots
- ☐ Tuberculosis

Gastrointestinal

- ☐ Appendicitis
- ☐ Celiac Disease
- ☐ Constipation
- ☐ Crohn's disease
- ☐ Diarrhea
- ☐ Diverticulitis
- ☐ Gastric Bypass
- ☐ Ulcer
- ☐ GERD
- ☐ Irritable Bowel Syndrome
- ☐ Ulcerative Colitis
- ☐ Opioid Induced Constipation

Gynecological

- ☐ Endometriosis
- ☐ Hot Flashes
- ☐ Post Menopausal
- ☐ Uterine Fibroids
- ☐ Painful Menstruation (Dysmenorrhea)

Genitourinary

- ☐ Erectile Dysfunction
- ☐ Chronic Kidney Disease
- ☐ Kidney Stones
- ☐ Overactive Bladder
- ☐ Urinary Incontinence

Endocrine

- ☐ Diabetes, Type 1
- ☐ Diabetes, Type 2
- ☐ Diabetic Neuropathy
- ☐ High Cholesterol
- ☐ Obesity
- ☐ Low Sexual Desire
- ☐ Hyperthyroid
- ☐ Hypothyroid

Cancer

- ☐ Specify_____

Patient Signature:_____ Date:_____

ADDITIONAL PHYSICIAN DIAGNOSED ILLNESSES, SURGERIES, HOSPITALIZATION

In the lines provided below, please list any additional physician diagnosed illnesses, surgeries, and hospitalizations:

Please list any allergies and the type of reaction below:

Allergic to: (i.e. Latex)	Type of reaction: (i.e. Hives)

Are you a female of childbearing potential?

- ☐ No
- ☐ Yes; Please indicate method of contraception_____

Patient Signature:_____ Date:_____

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of this Notice of Privacy Practices:

Signature: _____

Printed Name: _____

Date: _____

If you are signing as the patient's representative:

Signature: _____

Printed Name: _____

Describe Authority: _____

Date: _____