Olympian Clinical Research

Today's Date: _____

Would you like to be contacted when other studies become available that you might qualify for? (*Circle one*): Yes ***or*** No

Would you like to receive text message appointment reminders? (*Circle one*): Yes ***or*** No

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

First Name **Middle** **Last Name**

Date of Birth **Gender at Birth** **Email Address**

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

Primary Language (*Check one*):

□ English □ *Spanish** □ *Other** _____

If Spanish or Other, are you comfortable speaking, reading and writing in English?* □ Yes ***or* □ No

Phone Number(s) as applicable: Home: **Cellular:** **Work:**

Please indicate if it is Ok to leave detailed phone messages? □ Yes* ***or*** □ No

***If yes, please indicate which phone(s) by checking all that apply:** □ **Home** □ **Cellular** □ **Work**

Home Street Address: **Apt. or Unit #**

City: **State:** **Zip Code:**

Emergency Contact Name: **Relationship:** **Emergency Contact Phone Number:**

Primary Care Physician's Name *or* Last Provider Seen: **Provider's Phone Number:**

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

_____ _____

Patient Signature **Date**

RELEASE OF MEDICAL RECORDS

AUTHORIZATION TO RELEASE RECORDS FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION INCLUDING PSYCHIATRIC/PSYCHOLOGICAL PHI 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 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) and/or organization(s):

Release to:

Olympian Clinical Research
4700 N. Habana Ave.
Suite 303
Tampa, FL 33614
Telephone Number: 813-849-5566
Fax Number: 813-868-3050

Olympian Clinical Research
1201 S. Myrtle Ave.
Clearwater, FL 33756
Telephone Number: 727-935-0503
Fax: 727-935-0509

I specifically authorize the use and Disclosure of my 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. Additionally, I understand that the information used or disclosed under this authorization may be subject to additional disclosure by the recipient and may not be protected by federal HIPAA privacy regulations.

I understand that 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 to do so. However, I understand that such revocation will not have any effect on any information that has already been used or obtained by Olympian Clinical Research prior to receipt of any written notice of revocation.

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

_____ _____ _____

Signature of Witness **Printed Name of Witness** **Date**

AUTHORIZATION TO SHARE MEDICAL PROCEDURE AND LAB RESULTS

This form is an authorization form to elect to share any of your medical procedure/lab results or not. You may elect to share results or NOT to share results by indicating your preference below. Please note that your choice does not affect any potential study participation now or in the future.

Please Initial next to one of the following options for sharing medical procedure and lab results:

_____ If I participate in a study, **I elect to share any test results with my Primary Care Physician.**
Initials

_____ If I participate in a study, **I do NOT elect to share any test results with my Primary Care Physician.**
Initials

_____ If I participate in a study, **I elect to share any test results with another Physician, Provider or**
Initials **Designee other than my Primary Care Physician as indicated below:**

Name and Phone Number: _____

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

_____ _____
Patient Signature **Date**

_____
Printed Name of Patient

_____ _____
Signature of LAR or Caregiver (As Applicable) -or- ☐ NA **Date**

_____
Printed Name of LAR or Caregiver (As Applicable) -or- ☐ NA

MEDICATION HISTORY

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

Medication and Daily Dose	**Reason for Use**	**Start Date**	**Stop Date** or **Ongoing**

Patient Signature **Date**

Please check all Past and Current 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)
- ☐ Shingles
- ☐ Sun damage (Photoaging)
- ☐ Vitiligo

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
- ☐ Parkinson's Disease
- ☐ Post-Traumatic Stress Disorder
- ☐ Schizophrenic Disorders
- ☐ Seizure
- ☐ Stroke/ TIA
- ☐ Suicide Attempt(s)
- ☐ Tourette's Syndrome

Respiratory

- ☐ Allergies (seasonal)
- ☐ Asthma
- ☐ Bronchitis/ Sinusitis
- ☐ COPD
- ☐ Cystic/Pulmonary Fibrosis
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Sleep Apnea
- ☐ COVID-19

Musculoskeletal

- ☐ Chronic Pain: _____
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Sciatica

Cardiovascular

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

Infectious Disease

- ☐ HIV/AIDS
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Tuberculosis (TB)

Hematological

- ☐ Anemia
- ☐ Blood Clots (DVT, PE)

Gastrointestinal

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

Gynecological

- ☐ Endometriosis
- ☐ Hot Flashes
- ☐ PCOS
- ☐ 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
- ☐ Obesity
- ☐ Low Sexual Desire
- ☐ Hyperthyroid
- ☐ Hypothyroid (low)

Cancer

- ☐ Specify type: _____

_____ _____

Patient Signature **Date**

ADDITIONAL DIAGNOSED ILLNESSES, SURGERIES, HOSPITALIZATIONS

Please **list any additional diagnosed illnesses, surgeries, and hospitalizations with dates:**

Please **list any Allergies** and the **type of Reaction(s)**:

Allergic to: (latex, food, antibiotics, etc.)	**Type of Reaction:** (hives, rash, etc.)

Are you a female of childbearing potential?

- ☐ No
- ☐ Yes, please indicate method of contraception (birth control): _____

_____ _____

Patient Signature **Date**

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT

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

Patient Signature: _____ Date: _____

Patient Printed Name: _____

If you are signing as the Patient's Representative, please sign below to acknowledge receipt of the Notice of Privacy Practices -**or**-☐ NA:

Representative Signature: _____ Date: _____

Representative Printed Name: _____

Describe Authority: _____