K2 MEDICAL RESEARCH

PATIENT DEMOGRAPHICS

First Name:	Last Name:	Middle Initial:
Address:		
City:	State:	Zip Code:
Main Phone:	Cell Phone No.:	Age:
Email:		
Date of Birth: _____ / _____ / _____	Marital Status: ☐ Married ☐ single ☐ Widow(er)	Sex: ☐ Male ☐ Female
Race:	☐ Caucasian ☐ Asian ☐ Native Hawaiian / Other Pacific Islander ☐ Black African American ☐ Native American/Alaska Native ☐ Other	
Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Other	Native Language:	

PHYSICIAN INFORMATION

Physician Name:		
Address:		
City:	State:	Zip Code:
Main Phone:	Fax No.:	Last Exam Date:

IN CASE OF EMERGENCY

Name of Local Friend or Relative:	Relationship to Patient:	Phone No.:
Email:		

Patient / LAR Signature: ____ Date:

The above information is true to the best of my knowledge. I authorize K2 Medical Research to collect, review and store my information for future reference. I also authorize to be contacted by a third party that will provide support during my participation with K2 Medical Research to learn more about resources in my area.

Front Desk Initials: _____________ Reviewed by (staff initials and date): ______________________________

MEDICAL AND SURGICAL HISTORY			☐ NONE
History / Condition / Procedure USE PRECISE MEDICAL TERMINOLOGY DIAGNOSIS, IF POSSIBLE	**Date of Onset** DD / MMM / YYYY	**Date of Resolution** DD / MMM / YYYY	**Ongoing?**
			☐ NO ☐ YES
			☐ NO ☐ YES
			☐ NO ☐ YES
			☐ NO ☐ YES
			☐ NO ☐ YES
			☐ NO ☐ YES
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			☐ NO ☐ YES
			☐ NO ☐ YES
			☐ NO ☐ YES
			☐ NO ☐ YES
			☐ NO ☐ YES
			☐ NO ☐ YES
			☐ NO ☐ YES
			☐ NO ☐ YES

Have you ever participated in a clinical trial? ☐ Y ☐ N Are you currently enrolled in a clinical trial? ☐ Y ☐ N

If YES, when was your last dose date? ____ / ____ / ____

If YES, when was your last visit? ____ / ____ / ____

Additional Comments -OR- ☐ N/A: ____

Reviewed by (staff initials and date) __________

CURRENT MEDICATIONS ☐ NONE

Medication	Dosage	Onset DD / MMM / YYYY	Date of Resolution DD / MMM / YYYY	Reason for Use

List of Allergies ☐ NONE

Additional Comments -OR- ☐ N/A: ____

____

____

Reviewed by (staff initials and date) __________

101 Southhall Lane, Suite 150
Maitland, FL 32751
Phone: 407-500-5252 • Fax: 407-487-4598

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

This form complies with Health Insurance Portability & Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: ______________________________

Patient Date of Birth: ______________ Patient Phone Number: ______________

RELEASE OF INFORMATION FROM:	RELEASE OF INFORMATION TO:
______________ Doctor/Facility	K2 Medical Research 101 Southhall Lane, Suite 150 Maitland, FL 32751
______________ Address ______________	
______________ Phone Number	407-500-5252 Phone Number
______________ Fax	407-487-4598 Fax

I ______________________ give permission to disclose any medical information contained in my records including but not limited to discharge summaries, progress notes, medical history, medication list with start dates, physical examinations and laboratory or other diagnostic testing. I also grant K2 Medical Research the authorization to disclose medical information to the above doctor/facility. The specific purpose for disclosure of records is for the evaluation of clinical research trials.

I understand that the information in my health record may include information related to acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) or other sexually transmitted diseases. It may also include information related to behavioral and/or mental health and/or substance abuse services/treatment, unless indicated below.

Please send (check all applicable):

○ Last two progress notes
○ ECG
○ Lab Results
○ Pathology Results
○ Imaging Results
○ Psychiatric/Psychologic Evaluation
○ Other: ______________________

I do NOT authorize the following information to be included: ______________________
(leave blank in none)

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. This authorization shall remain in force for **one year** from the date of authorization. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand uses and disclosures already made based upon my original permission cannot be taken back.

I understand that information included may include records/reports from other health care providers involved in my care or treatment.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

______________________________ ______________________
Patient Signature Authorization Date

____
Patient's Printed Name

______________________________ ______________________
Witness Signature Date

____
Witness Printed Name

____
Legally Authorized Representative's Signature and Date, if applicable

____
Legally Authorized Representative's Printed Name, if applicable

Consent to Verbally Disclose Protected Health Information to Family Members and Friends

Subject Name: ______________________________ DOB: ____________________

You have the right to identify family, friends or others involved in your care to verbally receive study and/or medical information about you, to help you manage your care. You may add to or change this list at any time. K2 Medical Research will only verbally share your study or health information with the individuals you designate below except as required or permitted by law. This consent form is for verbal discussion of study and health related information and does not authorize obtaining or releasing written medical records. Completion of this form is **optional.**

I consent for K2 Medical Research to verbally disclose the information I have specified below with the following family, friends or others who are involved in my health care:

Name	Relationship to You	Phone Number

Type of information I authorize to be verbally discussed (Select all that apply):

☐ **All study and health related information (including genetic testing, cognitive and physical assessments, imaging results, lab results, medications, medical history and study details)**

☐ **Other (Specify): ____**

____

I understand that I have the right to revoke or revise these permissions at any time. I understand that this consent shall remain in effect until revoked in writing. All new versions of this form received will automatically supersede previous versions. I understand that this form is for the verbal disclosure and discussion of my health and study related information and does not grant permission for K2 Medical Research to release written medical records.

______________________________ ______________________________

Signature of Patient/Legally Authorized Individual — Date of Signature

______________________________ ______________________________

Printed Name of LAR (only if applicable) — Relationship to Subject (only if signed by LAR)

Version 1.0 Dated 11Mar2024 Effective 18Mar2024