WATSON CLINIC CENTER FOR RESEARCH, INC.
Diving Fatality Report Release

AUTHORIZATION FOR RELEASE OF INFORMATION FOR RESEARCH PURPOSES

I, (first name, last name): _____, hereby authorize the use and disclosure to Dr. Doug Ebersole of identifiable health information as described below, for the purpose of the study *Prospective Observational Study of Decompression Sickness in Scuba Divers with Patent Foramen Ovale*. By signing this authorization, I understand that any health information that is disclosed to the receiving organization identified below will not be protected from further disclosure by the Privacy Rule. However, the receiving organization will disclose or use my information only as described below under "Use of Disclosed Information." I understand that this authorization is voluntary.

Persons/organizations providing the the information:

_____
_____
_____
_____

Organization receiving the information:
Watson Clinic Center for Research, Inc.
Attn: Research Study Coordinator
1600 Lakeland Hills Boulevard
Lakeland, FL 33805

Specific description of information (including date(s)): medical record of PFO diagnosis, PFO closure, decompression sickness evaluation and treatment, and adverse events related to PFO closure.

Use of Disclosed Information. The protected health information will be used by study team solely to investigate risk/benefit of diving with PFO closure and for no other purposes. The receiving organization will not disclose the protected health information to any party other than those employees, representatives and agents of DAN who have a need to know such information to conduct such research.

1. I understand that this authorization will expire three years after the date of signature.

   __ __/__ __/__ __ __ __ (DD/MM/YYYY) Initials: _____

2. I understand that I may revoke this authorization at any time by notifying in writing the organization releasing my information, but if I do such revocation will not affect any action prior to receipt of my revocation. Initials: _____

_____

Signature

_____

Printed Name

_____

Date

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION