



111 Michigan Avenue NW
Washington, DC 20010-1970

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FOR ADPKD STUDY:

DATE: _____

PATIENT PHYSICIAN:

(LAST NAME) (FIRST NAME)

(ADDRESS)

(ADDRESS)

(ADDRESS)

PATIENT:

(LAST NAME) (FIRST NAME)

(ADDRESS)

(DATE OF BIRTH)

(MOTHER'S LAST NAME, MAIDEN, FIRST)

(FATHER'S LAST NAME, MIDDLE, FIRST)

The above named patient or their parents have signed a research Informed Consent to enroll in the above named research study that is being conducted at the Children's National Hospital.

With this Authorization for Release of Medical Information, we are requesting a copy of the data elements (listed below) from the patient's medical record in order to enter these clinical data into our IRB-approved Clinical Database.

The Principal Investigator for this study is Lisa M. Guay-Woodford. Records should be mailed to Dr. Guay-Woodford, who can be reached at (202) 476-6439.

Lisa M. Guay-Woodford, MD
CRI-CTS 6th Floor M7659
111 Michigan Avenue, NW
Washington, DC 20010

The Research Coordinator is Ms. Jasmine Jaber, Clinical Research Coordinator. Ms. Jaber can be reached at 202-476-2838 with any questions or concerns.

RELEASE THE FOLLOWING INFORMATION:

- Problem List
- Medication List
- Ambulatory Treatment Records (clinic visits)
- Emergency Room Records
- Outpatient Reports
- Consultation Reports
- History and Physical Reports
- Discharge Summary Reports
- Laboratory Results
- Radiology Reports
- Other: **Genetic Test Results**

PATIENT/PARENTAL AUTHORIZATION

- I understand the above named individual's health information may include information relating to sexually transmitted diseases, genetics, sexual activity including contraceptive methods, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) where applicable. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse in accordance to 42 CFR Part 2.
- I understand that I have the right to revoke this authorization at any time. If I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to process a claim under my policy. **This authorization will not expire during the course of the study.**
- I understand that authorizing the disclosure of this health information is voluntary. I understand that there are fees associated with redisclosures excluding for direct patient care (i.e. practitioner to practitioner communication). **Fee for copies are \$0.39/pg+postage when applicable* I understand that I may inspect the information to be used or disclosed as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for unauthorized redisclosures and the information may not be protected by federal confidentiality rules.

I, do hereby, declare that I am the patient/parent/legal guardian and am responsible for the release of information with regard to the above named patient. (Appropriate documentation will need to be provided with authorization in order to process release).

NOTE: If patient is of legal age (18), patient will need to sign the release themselves.

Signature of Patient	Signature of Parent or Legal Guardian	Date
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Email Address	Print Name of Parent or Legal Guardian	Witness
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