<date>

Dear Mr./Ms. *<name>*:

Thank you for taking part in the National CADDRE Study: Child Development and Autism. An important part of this study is to collect information from medical records.

Collecting information from medical records will help us to learn about medical events and history that may be important to child development. Medical records often contain important information that is difficult to remember, such as fevers or illnesses, prescribed medications, and exact dates. For this reason, we would like to look at the medical records of the biological mother from all medical providers seen during the three years prior to *<child's name>* date of birth. We would also like to look at the birth hospital record and pediatric records of your child. It is very important for us to look at the records of all types of families, even if the family does not have a child who has a developmental delay. Learning more about the differences in children's medical records may give us clues about child development.

We must have your written consent in order to collect information from medical records. By signing the enclosed Health Insurance Portability and Accountability Act (HIPAA) forms for each provider, you give us permission to collect information from the medical records. Further, we ask that you please mark off the type of provider for which you have given us permission to contact on the check list in the enclosed packet.

It is important for us to look at records of biological mothers. If you are not the biological mother of your child, we ask that you please provide us with her contact information. You can write this information on the form instead of signing.

Please return the signed HIPAA forms and provider checklist in the envelope provided. You can also give the forms to study staff at your first study visit. If you have any questions about the study or the enclosed forms, you can call < *study coordinator contact info*>.

Thank you again for taking part in this important study.

Sincerely,

<Project Coordinator>

Provider Check List

Please check the box of all the providers for which you have given us permission to contact to access the biological mother's and child's medical records. We are asking you to complete this checklist to ensure that we have the ability to collect as complete medical information as possible on the biological mother and child.

Biological Mother:

□ Primary Care Physician (example: family doctor or internal medicine)
□ Obstetrician
□ Gynecologist
□ Allergist/Immunologist
□ Rheumatologist
□ Psychiatrist
□ Infertility specialist/reproductive endocrinologist
□ Other (Please specify): _____

Child in study:

□ Pediatrician
□ Developmental Pediatrician
□ Allergist/Immunologist
□ Psychiatrist
□ Neurologist
□ Other (Please specify): _____

CADDRE

***Health Information Portability and Accountability Act (HIPAA)* Medical Records Release Authorization Form**

Patient Name: _____

Phone: _____ **Street Address:** _____

Date of Birth _____ **SS # (last 4 digits)** _____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. I authorize the following individuals and/or organizations to make this disclosure:
   << site specific information>>

The information identified below may be used by or disclosed to the following individuals/organizations:
Name: *<< site specific information>>*
Address: *<< site specific information>>*

3. ☐ **I Authorize Release of <u>the ENTIRE medical record without exception</u>** .*NOTE: If you do not want to have your entire record reviewed, please check #4 below and select the types of information that you are willing to provide.*

   Medical Provider (name & address):

4. ☐ **I Authorize Release of** PARTIAL medical records**.** If parents do not wish to reveal the entire record.

Please specify the parts and dates to be released below.
Dates of Service:

Types of Information (Check all that apply below. *It is NOT necessary to check the boxes below, unless you disagree with statement #3 above)*:

☐ Gynecology & Obstetric Records	☐ Face Sheets/Registration Sheets	☐ Pathology Report
☐ Labor and Delivery Record	☐ HIV Information	☐ Post-Operative Reports
☐ Pediatric Record	☐ Hospital Admissions Information	☐ Procedural Information
☐ Anthropometric (growth) measurements	☐ Injection/Vaccination Information	☐ Progress Notes
		☐ Radiology (Ultrasound) Reports
☐ Consultation Reports	☐ Lab Results	☐ Referral Sheets
☐ Discharge Summary/Instructions	☐ Medication List	☐ Substance Abuse Information
☐ ER (emergency room) records	☐ Medical History	☐ Surgical History
	☐ Mental Health Information	☐ _____

5. The information that I am authorizing this disclosure will be solely used for the purpose of **state what kind of** _____research.
6. I understand that I have a right to revoke this authorization at any time. If I choose to revoke this authorization, I must do so in writing, and submit my written request to the medical records department of this facility. I also understand that any information that the researchers collect before I choose to revoke this authorization will be retained by the researchers.
7. I understand that unless revoked, this authorization will expire at the end of the CADDRE case cohort research study.
8. I understand that because sensitive information is collected in this study, <<CDC>> received a <<'Certificate of Confidentiality.'>> This means that any information that <<CDC>> has that identifies you or your child will be used only for this project. It cannot be **given, used, or disclosed** to anyone else unless you give your written consent (or unless required by law).
9. I understand that this disclosure is voluntary and my decision to authorize or not authorize the release of this

information will not affect my ability to be treated at the above mentioned facilities.

Participant Signature	Date
If signed by legal representative, relationship to participant	Date
Signature of Witness	Date