BOSTON MEDICAL CENTER

BOSTON UNIVERSITY MEDICAL CAMPUS

RESEARCH SUBJECT'S AUTHORIZATION

FOR RELEASE OF HEALTH INFORMATION FOR RESEARCH PURPOSES

Name of Research Study: The Framingham Heart Study
73 Mt. Wayte Avenue, Suite #2, Framingham, MA 01702-5827

IRB Number: 1910G

Subject's Name: _____ **Birth Date:** _____

We want to use your private health information in this research study. This will include both information we collect about you as part of this study as well as health information about you that is stored in your medical records. The law requires us to get your authorization (permission) before we can use your information or share it with others for research purposes. You can choose to sign or not to sign this authorization. If you choose not to sign this authorization, you will still be able to take part in the research study.

Section A:

I authorize the use or sharing of my health information as described below:
Who will be asked to give us your health information:

- **Hospitals and physicians you have identified as providing medical care for a reported health problem**

Who will be able to use your health information for research:

- **The researchers and research staff conducting the Framingham Heart Study.**

Section B: Description of information:

(1) The researchers need to collect information about you and your health. This will include information collected during the study as well as information from your existing medical records so we can review the health problem(s) you have reported to us. The information disclosed under this authorization will not be redisclosed to anyone but the researchers conducting this study except as required by law.

(2) I authorize _____ **to release to the**
(List name of hospital/physician or clinic)

Framingham Heart Study the following information from my medical records. Disclose the following information for the dates ranging from _____ **to** _____.

Specific description of information we will collect may include:

- •Face Sheet
- •Discharge Summary
- •ER Report
- •Admission Notes
- •Progress Notes
- •Operative Report
- •Pathology report
- •Chest X-Rays
- •EKGs (All)
- •CT Scan (Head)
- •MRI/MRA (Head/Neck)
- •Lab Reports - Cardiac Enzymes
- •Consults (Cardiology & Neurology)
- •Cardiac Catheterization
- •Exercise Tolerance Test
- •Nursing Home Notes
- •Notes near time of death
- •Other: (for example: Echocardiogram, Arteriography, Venous Ultrasound, V/Q Scan, PA gram, etc.)

Section C: General

(1) Expiration:
This authorization expires at the end of the study.

(2) Right To Revoke:
You may revoke (take back) this authorization at any time. To do this, you must ask the Framingham Heart Study for the names of the Privacy Officers at the institutions where we got your health information. You must then notify those Privacy Officers in writing that you want to take back your Authorization. If you do, we will still be permitted to use the information that we obtained before you revoked your authorization but we will only use your information the way the Informed Consent Form says. If it is easier for you, please contact Lynne McDonald, head of Medical Records, and she will help you take back your authorization.

(3) Your Access to the Information:
You have the right to see your medical records, but you will not be allowed to review medical records in your research records until after the study is completed.

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I have read this information, and I will receive a signed copy of this form.

_____ _____

Signature of research subject or personal representative **Date**

Printed name of personal representative: _____

Relationship to research subject: _____

Please describe the personal representative's authority to act on behalf of the subject:

_____

ACCEPTED
Date: 4/14/03
Sig:
Research Privacy Advocate