





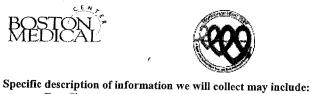
## RESEARCH SUBJECT'S AUTHORIZATION

## FOR RELEASE OF HEALTH INFORMATION FOR RESEARCH PURPOSES

	The Framingham Heart Study
	73 Mt. Wayte Avenue, Suite #2, Framingham, MA 01702-5827
IRB Number: 1910	
Subject's Name:	Birth Date:
is stored in your medical r before we can use your inf	the health information in this research study. This will include both out you as part of this study as well as health information about you that ecords. The law requires us to get your authorization (permission) ormation or share it with others for research purposes. You can choose uthorization. If you choose not to sign this authorization.
Section A:	
I authorize the use or shar	ing of my health information as described below:
<ul> <li>Hospitals and physhealth problem</li> <li>Who will be able to use you</li> </ul>	ing of my health information as described below:  Is your health information:  Icians you have identified as providing medical care for a reported  Ir health information for research:  It d research staff conducting the Framingham Heart Study.
Hospitals and phys health problem Who will be able to use you The researchers an  Section B: Description of in  The researchers need to information collected during so we can review the health need to	is your health information: icians you have identified as providing medical care for a reported ir health information for research: d research staff conducting the Framingham Heart Study.
Hospitals and phys health problem Who will be able to use you The researchers an  Section B: Description of in  (1) The researchers need to information collected durin so we can review the health p authorization will not be redisby law.	icians you have identified as providing medical care for a reported ir health information for research: d research staff conducting the Framingham Heart Study.  Information:  Information:  Information about you and your health. This will include g the study as well as information from your existing medical records roblem(s) you have reported to us. The information disclosed under this closed to anyone but the researchers conducting this study except as required.
Hospitals and phys health problem Who will be able to use you The researchers an  Section B: Description of in  (1) The researchers need to information collected durin so we can review the health p authorization will not be redisby law.	icians your health information: icians you have identified as providing medical care for a reported ir health information for research: d research staff conducting the Framingham Heart Study.  information: o collect information about you and your health. This will include g the study as well as information from your existing medical records

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•Face Sheet	•CT Scan (Head)
<ul> <li>Discharge Summary</li> </ul>	•MRI/MRA (Head/Neck)
•ER Report	•Lab Reports - Cardiac Enzymes
<ul> <li>Admission Notes</li> </ul>	•Consults (Cardiology & Neurology)
<ul> <li>Progress Notes</li> </ul>	•Cardiac Catheterization
<ul> <li>Operative Report</li> </ul>	•Exercise Tolerance Test
<ul> <li>Pathology report</li> </ul>	•Nursing Home Notes
<ul> <li>Chest X-Rays</li> </ul>	•Notes near time of death
•EKGs (All)	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. ..... 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 subjectate: Research Privacy Authorization Research Privacy Advocate (FHS Version 1 April 7, 2003)