OMB#: 0925-0216
Exp. 12/2007

Public reporting burden for this collection of information is estimated to average 6 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0216). Do not return the completed form to this address.

To Whom It May Concern:

As part of the research study of the National Heart, Lung and Blood Institute, the Framingham Heart Study has been studying the causes of coronary disease and stroke for nearly fifty years. We are interested in completing our records on the person listed below who has been a participant in our long-term study.

Patient: ID#

Date of Birth:

Date(s):

Films Requested:

___Face Sheet
___Discharge Summary
___ER Report
___Admission Notes
___Progress Notes
___Operative Reports
___Pathology Reports
___Chest X-Rays
___EKGs (all)

___CT Scan (Head)
___MRI (Head)
___Lab Reports - Cardiac Enzymes
___Consults (Cardiac and Neuro)
___Cardiac Catheterization
___Exercise Tolerance Test
___Nursing Home Notes
___Notes near time of death
___ ____________________

We would appreciate borrowing the films requested. We will return them when our review is complete. The information you provide will be kept confidential, and will not be disclosed to anyone but the researchers conducting this study, except as otherwise required by law.

Please send Films to: Attn: MEDICAL RECORD DEPARTMENT

Thank you for your kind assistance in this matter.

Sincerely yours,

Daniel Levy, M.D.
Medical Director
Framingham Heart Study

DL/lm

To Whom It May Concern:

As part of the research study of the National Heart, Lung and Blood Institute in Framingham, Massachusetts into the causes of coronary disease and stroke, we are interested in completing our records on the person listed below who was in our study and had died within your jurisdiction.

Name: ID#
Date of Death:

Date of Birth:

We would appreciate a copy of the death certificate. The information you provide will be kept confidential, and will not be disclosed to anyone but the researchers conducting this study, except as otherwise required by law.

Please use enclosed return envelope or send reply/information to:
Attn: MEDICAL RECORDS DEPARTMENT

Thank you for your kind assistance.

Sincerely yours,

Daniel Levy, M.D.
Medical Director
Framingham Heart Study

DL/lm

Dear Dr:

As part of the research study of the National Heart, Lung and Blood Institute, the Framingham Heart Program has been studying the causes of coronary disease and stroke for nearly fifty years. We are interested in completing our records on the person listed below who has been a participant in our long-term study.

Patient: ID#

Date of Birth:

Records pertaining to:
Date:

We would appreciate copies of the records requested. A return envelope is enclosed for your convenience. The information you provide will be kept confidential, and will not be disclosed to anyone but the researchers conducting this study, except as otherwise required by law.

Please use enclosed return envelope or send reply/information to:
Attn: MEDICAL RECORDS DEPARTMENT

Thank you for your kind assistance in this matter.

Sincerely yours,

Daniel Levy, M.D.
Medical Director
Framingham Heart Study

DL/lm

To Whom It May Concern:

As part of the research study of the National Heart, Lung and Blood Institute, the Framingham Heart Study has been studying the causes of coronary disease, stroke, cancer and other major diseases for nearly sixty years. We are interested in completing our records on the person listed below who has been a participant in our long-term study.

Patient: ID

Date of Birth:

Date(s):
Records Requested:

- ___Face Sheet
- ___Discharge Summary
- ___ER Report
- ___Admission Notes
- ___Progress Notes
- ___Operative Reports
- ___Pathology Reports
- ___Chest X-Rays
- ___EKGs (all)
- ___Exercise Tolerance Test
- ___Echocardiogram
- ___CT Scans
- ___MRI/MRAs
- ___EEG
- ___Ultrasound
- ___Lab Reports - Cardiac Enzymes
- ___Consults (Cardiac and Neuro)
- ___Cardiac Catheterization
- ___Nursing Home Notes
- ___Notes near time of death
- ___Pronouncement Note
- ___ ____________________

We would appreciate copies of the records requested. A return envelope is enclosed for your convenience. The information you provide will be kept confidential, and will not be disclosed to anyone but the researchers conducting this study, except as otherwise required by law.
Please use enclosed return envelope or send reply/information to:
Attn: MEDICAL RECORDS DEPARTMENT

Thank you for your kind assistance in this matter.

Sincerely yours,

Daniel Levy, M.D.
Medical Director
Framingham Heart Study

DL/lm

Dear :

As part of the research study of the National Heart, Lung and Blood Institute in Framingham, Massachusetts into the causes of heart disease and stroke, we are interested in updating our records on you. In order to do that we would like to obtain a copy of your medical records from the following:

Could you please help us by signing the authorization form(s) and returning it to us in the enclosed envelope as soon as possible. The information you provide will be kept confidential, and will not be disclosed to anyone but the researchers conducting this study, except as required by law.

Please use enclosed return envelope or send reply information to: Attn: MEDICAL RECORDS DEPARTMENT

We will be most grateful for your cooperation.

Sincerely yours,

Daniel Levy, M.D.
Medical Director
Framingham Heart Study

DL/lm
OMB # 0925-0216

TO WHOM IT MAY CONCERN:

I hereby authorize

to release to the Framingham Heart Study
73 Mt Wayte Ave.
Framingham, MA 01702

the following protected health information from my medical record.

Patient Name: Date of Birth:
Address:

Disclose the following information for dates:

* Face Sheet
* Discharge Summary
* ER Report
* Admission Notes
* Progress Notes
* Operative Report
* Pathology Report
* Chest X-Rays
* EKGs (All)
* Echocardiogram
* Holter Monitor
* CT Scan(s)
* MRI/MRA(s)
* Lab Reports - Cardiac Enzymes
* Consults (Cardiac & Neuro)
* Cardiac Catheterization
* Exercise Tolerance Test
* Carotid Ultrasound
* EEG
* Nursing Home Notes
* Notes near time of death
* Pronouncement Note
* Other ______________________________

The purpose for this disclosure is research.

The information disclosed under this authorization **will not be redisclosed** to anyone but the researchers conducting this study, except as required by law.

I understand I may revoke this authorization at any time by requesting such of the above referenced physician/hospital in writing. If I do it will not have any effect on actions that the hospital/physician took before it received the revocation.

This authorization expires at the end of the research study.

DATE: ____________________ SIGNED: ________________________
OMB # 0925-0216

Dear ,

As part of the research study of the National Heart, Lung and Blood Institute, the Framingham Heart Program has been studying the causes of coronary heart disease and stroke for over fifty years.

As you know, is a participant in the Heart Study. In order to review her record, we would like permission to obtain copies of her medical record(s) from the following:

Would you be willing to help us by signing the enclosed authorizations(s) **and sending a copy of the Power of Attorney/ Executor Appointment papers** (if available) so that we can obtain the medical record(s).

Please return it to us in the enclosed envelope as soon as possible. The information you provide will be kept confidential, and will not be disclosed to anyone but the researchers conducting this study, except as otherwise required by law. Please use enclosed return envelope or send reply/information to: Attn: MEDICAL RECORDS DEPARTMENT

We will be most grateful for your cooperation.

Sincerely yours,

Daniel Levy, M.D.
Medical Director
Framingham Heart Study

DL/lm
OMB # 0925-0216

TO WHOM IT MAY CONCERN:

I hereby authorize

to release to the Framingham Heart Study
73 Mt Wayte Ave.
Framingham, MA 01702

the following protected health information from medical record.

Patient Name: Date of Birth:
Address:

Disclose the following information for dates ranging from:
to

* Face Sheet
* Discharge Summary
* ER Report
* Admission Notes
* Progress Notes
* Operative Report
* Pathology Report
* Chest X-Rays
* EKGs (All)
* Echocardiogram
* Holter Monitor
* Other ______________________________
* CT Scan(s)
* MRI/MRA(s)
* Lab Reports - Cardiac Enzymes
* Consults (Cardiac & Neuro)
* Cardiac Catheterization
* Exercise Tolerance Test
* Carotid Ultrasound
* EEG
* Nursing Home Notes
* Notes near time of death
* Pronouncement Note

The purpose for this disclosure is research.

The information disclosed under this authorization **will not be redisclosed** to anyone but the researchers conducting this study, except as required by law.

I understand I may revoke this authorization at any time by requesting such of the above referenced physician/hospital in writing. If I do it will not have any effect on actions that the hospital/physician took before it received the revocation.

This authorization expires at the end of the research study.

______________________________ DATE

______________________________ SIGNED

______________________________ PRINTED NAME

______________________________ RELATIONSHIP TO PATIENT OR AUTHORITY TO ACT FOR PATIENT

OMB # 0925-0216

Dear ,

As part of the research study of the National Heart, Lung and Blood Institute, the Framingham Heart Program has been studying the causes of coronary heart disease, stroke and other diseases for over fifty years.

As you know, is a participant in the Heart Study. In order to review her record, we would like permission to obtain copies of her medical record(s) from the following:

Could you please help us by signing the enclosed authorization form(s) and return it to us in the enclosed envelope as soon as possible. The information you provide will be kept confidential, and will not be disclosed to anyone but the researchers conducting this study, except as otherwise required by law.

Please use enclosed return envelope or send reply/information to: Attn: MEDICAL RECORDS DEPARTMENT

We will be most grateful for your cooperation.

Sincerely yours,

Daniel Levy, M.D.
Medical Director
Framingham Heart Study

OMB # 0925-0216
DL/lm

TO WHOM IT MAY CONCERN:

I hereby authorize

to release to the Framingham Heart Study
73 Mt Wayte Ave.
Framingham, MA 01702

the following protected health information from
medical record.

Patient Name: Date of Birth:
Address:
Framingham, MA 01701

Disclose the following information for dates ranging from:
to

* Face Sheet
* Discharge Summary
* ER Report
* Admission Notes
* Progress Notes
* Operative Report
* Pathology Report
* Chest X-Rays
* EKGs (All)
* Echocardiogram
* Holter Monitor
* CT Scan(s)
* MRI/MRA(s)
* Lab Reports - Cardiac Enzymes
* Consults (Cardiac & Neuro)
* Cardiac Catheterization
* Exercise Tolerance Test
* Carotid Ultrasound
* EEG
* Nursing Home Notes
* Notes near time of death
* Pronouncement Note
* Other ______________________________

The purpose for this disclosure is research.

The information disclosed under this authorization **will not be redisclosed** to anyone but the researchers conducting this study, except as required by law.

I understand I may revoke this authorization at any time by requesting such of the above referenced physician/hospital in writing. If I do it will not have any effect on actions that the hospital/physician took before it received the revocation.

This authorization expires at the end of the research study.

DATE ______________________ SIGNED ______________________

PRINTED NAME ______________________ RELATIONSHIP TO PATIENT OR AUTHORITY TO ACT FOR PATIENT ______________________

OMB # 0925-0216

Dear ,

Please accept our most sincere condolences on the death of . We at the Framingham Heart Study appreciate her dedication to our research.

As part of the research study of the National Heart, Lung and Blood Institute, the Framingham Heart Study has been studying the causes of coronary heart disease and stroke for over fifty years.

In order to review her record, we would like permission to obtain copies of medical record(s) from the following:

Would you be willing to help us by signing the enclosed authorizations(s) and sending a copy of the Power of Attorney/ Executor Appointment papers (if available) so that we can obtain the medical record(s).

Please return it to us in the enclosed envelope at your earliest convenience. The information you provide will be kept confidential, and will not be disclosed to anyone but the researchers conducting this study, except as otherwise required by law. Please use enclosed return envelope or send reply/information to: Attn: MEDICAL RECORDS DEPARTMENT

Again, we offer our sincere condolences and are grateful for your cooperation.

Sincerely yours,

Daniel Levy, M.D.
Medical Director
Framingham Heart Study

DL/lm
OMB # 0925-0216

TO WHOM IT MAY CONCERN:

I hereby authorize

to release to the Framingham Heart Study
73 Mt Wayte Ave.
Framingham, MA 01702

the following protected health information from medical record.

Patient Name: Date of Birth:
Address:

Disclose the following information for dates:

* Face Sheet
* Discharge Summary
* ER Report
* Admission Notes
* Progress Notes
* Operative Report
* Pathology Report
* Chest X-Rays
* EKGs (All)
* Echocardiogram
* Holtor Monitor
* Other ______________________________
* CT Scan(s)
* MRI/MRA(s)
* Lab Reports - Cardiac Enzymes
* Consults (Cardiac & Neuro)
* Cardiac Catheterization
* Exercise Tolerance Test
* Carotid Ultrasound
* EEG
* Nursing Home Notes
* Notes near time of death
* Pronouncement Note

The purpose for this disclosure is research.

The information disclosed under this authorization will not be redisclosed to anyone but the researchers conducting this study, except as required by law.

I understand I may revoke this authorization at any time by requesting such of the above referenced physician/hospital in writing. If I do it will not have any effect on actions that the hospital/physician took before it received the revocation.

This authorization expires at the end of the research study.

______________________________ ______________________________
DATE SIGNED

______________________________ ______________________________
PRINTED NAME RELATIONSHIP TO PATIENT OR AUTHORITY TO ACT FOR PATIENT