ATTACHMENT D

Medical Records Request and Authorization of Release Form

Medical Records Request and Authorization of Release Form

Participant Identification Number:_____

REQUEST AND AUTHORIZATION OF MEDICAL RECORDS RELEASE FORM

If you sign this document, you give permission to all health care providers listed on the attached sheet to release health information that identifies your child for the research study described below:

> The *Natural History of Spina Bifida in Children Pilot Project* will contribute to the final design of a project that will examine what it is like to grow up with spina bifida. The pilot project seeks to determine the best ways to collect information about children with spina bifida. The project is currently conducting telephone interviews with parents, in-person assessments with children and parents, and abstracting information from the medical records of children with spina bifida.

The health information that your child's health care providers may release for this research includes all information in your child's medical records (for example, results of physical examinations, medical history, lab tests, or health information indicating or relating to spina bifida). Specifically, the health care providers may release a copy of your child's entire medical records.

The health information listed above may be released to: TBD TBD who works on the Natural History of Spina Bifida in Children Pilot Project.

The health care providers that you list on the attached sheet are required by law to protect your child's health information. By signing this document, you authorize these health care providers to release your child's health information for this research. Those persons who receive your child's health information are not covered by the Federal HIPAA Privacy Rule. However, they will not release or share your child's information with anyone.

Your child's health care providers may not refuse to treat your child whether you sign this Authorization.

You may change your mind and take back this Authorization at any time except to the extent that your child's health care providers have already acted based on this Authorization. To revoke this Authorization, you must write to your child's health care providers.

This authorization expires at the end of the research study.

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Full Name of Child: _____
First Middle Last

Child's Date of Birth: _____
Month Day Year

Name of Parent/Legal Guardian: _____
First Middle Last

Signature of Parent/Legal Guardian: _____

Please provide the names, addresses, and telephone numbers of your child's previous and current medical providers below. If your child has never used a particular type of care, please write "NONE" on the line labeled "Name."

Clinic(s) or physician(s) providing urology care:

Name: _____

Address:_____

_____

_____

Phone: (_____) _____ - _____

Clinic(s) or physician(s) providing neurology/neurosurgery care:

Name: _____

Address:_____

_____

_____

Phone: (_____) _____ - _____

Clinic(s) or physician(s) providing orthopedic care:

Name: _____

Address:_____

_____

_____

Phone: (_____) _____ - _____

Clinic(s) or physician(s) providing other medical care:

Name: _____

Address:_____

_____

_____

Phone: (_____) _____ - _____

_____ _____

Signature of parent Date

Signature of witness   Date