Supporting Statement B

Attachment 15

Model Medical Release Form

MEDICAL RELEASE FORM

Model Release

WHI Clinical Coordinating Center
Fred Hutchinson Cancer Research Center
1100 Fairview Ave. N.,
Seattle, WA 98109-1024

WOMEN'S HEALTH INITIATIVE

AUTHORIZATION TO RELEASE MEDICAL RECORDS

The Women's Health Initiative Clinical Trial and Observation Study (WHI) is a 40-center national study sponsored by the National Institutes of Health to test preventive measures for cardiovascular disease, cancer, and fractures in post-menopausal women. By signing this document, I give permission to the Principal Investigator and the WHI Clinical Coordinating Center at the Fred Hutchison Cancer Research Center – Seattle, Washington, <<insert MD name>> and staff, to request my medical records.

I hereby authorize any and all medical facilities including:

_____

Name of Physician and/or medical institutions

To disclose medical records relating to the following conditions:

Hospitalizations (overnight admission)	*Procedures and Operations*
Fractures	*X-rays, Radiology reports, Procedure report*
Cardiovascular conditions	*Medical documents including and pertaining to Myocardial Infarction, CABGs, PTCAs, CHF, Strokes, EKGs, and other Cardiovascular disease*
Mammograms	*Reports only- NO FILMS*
Cancers	*Including screenings, Breast exams, Pelvic exams, Pap smears, Ultrasounds, Endometrial biopsies and Pathology reports*

By signing, I, acknowledge that I have read and understood the following:

Duration The authorization will remain in effect until its expiration on <<insert date>>.

Revocation This authorization may be revoked at any time by calling (800) XXX-XXXX. Revocation will be in effect immediately upon notification.

Re-disclosure Information in the above medical records may be shared with researchers at the <<institution>>,. the National Institutes of Health, and regulatory bodies such as the US Food and Drug Administration and the <<institution>> Institutional Review Board. Once disclosed this information may no longer be protected.
WHI **may not** further use or disclose the information in my medical records unless I sign another authorization giving them permission to do so or unless such use or disclosure is required and permitted by law. Any information that is re-disclosed by the <<institution>> will have my personal information blocked on all records.

After completion of the study, I will have the right to inspect or copy the information in my study file.

The records requested are required for data collection in the Women's Health Initiative Extension Study . My compliance, or refusal, to sign this authorization has no effect whatsoever on my enrollment in WHI Extension Study, nor my status as a participant.

INITIAL HERE IF YOU DESIRE A COPY OF THIS AUTHORIZATION _____

The following information is needed to assure accurate identification and is **ONLY for identification purposes**.

Patient Legal Name (Please Print)	Social Security Number (Optional)
Date of birth	Place of birth (Optional)
If another party is signing for participant, please list relationship:	Mother's Maiden Name (Optional)
Patient's Signature (or signature of party authorized to sign)	Date

This research organization is in full compliance with the Health Insurance Portability and Accountability Act of 1996. Copies of this signed authorization will be considered as valid as the original. N:\G\FORMS\WHI Forms\Medical Release HIPAA WHI DOC 06-04.doc