

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



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.

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