Appendix H
Consent to Obtain Health Information

Consent to Obtain Health Facts–
CONSENT FORM
Flesch-Kincaid Read Level: 8.0

STUDY ID NUMBER

Authorization for Use or Disclosure of Health Information

TREMOLITE ASBESTOS REGISTRY

Patient Name: _____
First Middle Last

Patient's Date of Birth: _____
Month/Day/Year

By signing this form, I give permission to release health information about me for research, as described in this document.

Description of information to be released , including dates related to the information:

ATSDR has my consent to contact my doctor(s) to get certain facts about my health. The doctor will only be asked (1) the name of my illness(es) and (2) the date of first treatment for my illness(es). Facts about me will be treated in a private manner. No facts that identify me or others for whom I acted as a proxy will be given out in any report of the findings.

Provider who may release my health information (provider name and address):

Please fill in the facts below. List the doctor or health care center where your illness was first found.

First Doctor or clinic:
Address:
City:
State:
Zip code:
Telephone:

Second Doctor or clinic:
Address:
City:
State:
Zip code:

Telephone:

Persons or groups of persons to whom my health information may be released:

Research staff at the Agency For Toxic Substances And Disease Registry, Atlanta, GA (ATSDR)

Research staff at RTI International, Research Triangle Park, NC (RTI)

Purpose for this release of my health information:

My health information will be used for public health research only.

This authorization expires (specific date, time period after signature, or "not applicable"):

Six months after signature.

I understand that I may cancel this authorization at any time informing my health care provider(s) in writing.

I understand that I may refuse to sign this form. I also understand that if I refuse, it will not affect my treatment, payment, enrollment in a health plan, or eligibility for benefits in any way.

By signing below, I give permission to the providers named above to release health information about me to staff at ATSDR and to staff at RTI International.

Signature of Patient or Patient's Personal Representative:

_____

Date: _____
Month/Day/Year

If signed by someone other than Patient:
Printed Name of Personal Signing for Patient: _____
First Middle Last

Nature of Relationship/Authority to Act for the Patient

(parent, guardian, etc.): _____

Disposition: Original to ATSDR; Copy kept by patient
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