Center for
Autism and
Developmental
Disabilities
Research and
Epidemiology

Form Approved
OMB NO. __________
Exp. Date __________

Study to Explore Early Development

<Name of provider>
<Address 1>
<Address 2>

<Date>

Dear *<provider>*,

One of your patients is participating in one of our research studies and has granted us permission to view her medical record. Enclosed you will find a signed release of health information form for *<mother's name>*.

Please provide a copy of all the documents in the patient's medical record that pertain to <<her prenatal care and labor and delivery during her pregnancy with *<child's name>*>. *<child's name>* was born on *< child's birthdate>*.

Please mail the requested medical record documents to the following address:

<Project Coordinator>
<Address 1>
<Address 2>
<Address 3>

If there is a charge associated with this request, please contact me by telephone at *<phone number>* and we will send a check to cover the service. **Please do not bill the patient**.

If you have any questions or need additional information, please do not hesitate to contact me. Thank you for your timely response to this request.

Sincerely,

<Project Coordinator>

Public Reporting Burden Statement
Public reporting burden of this collection of information is estimated to average 3 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 CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0741)