Medical Records Release Form: PLSND

Event:	Pregnancy Visit 1, Pregnancy Visit 2, Birth
Domain:	Questionnaire
Type of Document:	Form
Recruitment Groups:	PBS
Version:	1.0
Release:	MDES 3.3

This page intentionally left blank.

Medical Records Release Form: PLSND

AUTHORIZATION TO OBTAIN INFORMATION FROM MEDICAL RECORDS FOR THE NATIONAL CHILDREN'S STUDY

A.

Please provide the following contact information for the health care providers you saw during and following your pregnancy, including physicians, midwives, clinics, or hospitals.

Primary Provider's Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: (__)____—_____

Other Provider's Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: (__)____—_____

Other Provider's Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: (__)____—_____

Other Provider's Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: (__)____—_____

B.

I am voluntarily participating in the National Children's Study (NCS). I authorize and request that you provide the NCS with medical information they request about the labor and delivery services, and perinatal services, including treatment, testing, and test results provided to me and my child during and following my current pregnancy. This authorization form covers any care I or my child received at your facility, and from any medical provider associated with your facility or who provided care to me or my child in your facility. I understand that the Health Insurance Portability and Accountability Act of 1996 (HIPAA)[(1)] prohibits you from releasing my information without my authorization. This form (or a photocopy of this form) gives you my authorization. I have signed this form voluntarily, with the understanding that my decision to sign or not to sign the form will have no effect on my eligibility for treatment, payment, enrollment, or eligibility for any benefits to which I am entitled. I understand that NCS will use this information to supplement information I have already given to the NCS. I also understand that once my information is released to the study, it is no longer covered by HIPAA but is covered by the Public Health Service Act[(2)], which prohibits the release of information that would identify me or my medical providers outside the sponsoring agency and its contractors without my permission or that of my medical providers. I authorize the study to use information I have given in the survey to help you identify my records. I also understand that I can revoke this authorization at any time by contacting a study representative in writing or by telephone. Otherwise, this authorization expires 30 months from the date of signature. For questions about this release, please contact the NCS Office at [(XXX) XXX-XXXX].

C.	1.	Patient Name (first, middle, last): _____		
	2.	Date of Birth _____/_____/_____ **Month Day Year**	3.	Other Names Under Which Records May Be Filed _____
D.	4	_____ Patient's Signature	5.	Date Signed _____
E.	6.	_____ Witness or Proxy's Signature	7.	Date signed _____
	8.	_____ Signer's Relationship to Patient	9.	Reasons for Witness or Proxy's Signature: ❒ Patient Disabled ❒ Patient Deceased

(1) Health Insurance Portability and Accountability Act: 42 U.S.C. 1320d-2 and 1320d-4 and the implementing regulation, 45 CFR 164.508, require a detailed authorization for your health care provider to disclose health information from your records for research purposes.

(2) Public Health Service (PHS) Act: 42 U.S.C. 242m(d) protects the confidentiality of data collected under the research authorities of the National Institutes of Health. The National Children's Study will be carried out in compliance with these provisions as well as those in the Children's Health Act of 2000 (Public Law 106-310 Sec. 1004).