Death Certificate 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

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The National Children's Study
Death Certificate Release Form: PLSND

PARENT OR GUARDIAN AUTHORIZATION TO OBTAIN DEATH CERTIFICATE

<table>
<tr><td>A.</td><td colspan="4">Full Name of Parent/Guardian of Deceased: ____________________
Relationship to Deceased: ____________________
Street Address: ____________________
City: ____________________ State: __________ Zip: ________
Telephone: (___)____—__________</td></tr>
<tr><td>B.</td><td colspan="4">Full Name of Deceased Baby: ____________________
Sex of Baby: ❒ Male ❒ Female
Date of Death or Stillbirth: _____/_____/______
Month Day Year
Place of Death or Stillbirth—Hospital/Clinic: ____________________
Place of Death or Stillbirth—City: ____________________
Place of Death or Stillbirth—State: ____________________
Name of Doctor: ____________________
Name of Funeral Director: ____________________
Place of Burial: ____________________</td></tr>
<tr><td>B.</td><td colspan="4">I am voluntarily participating in the National Children's Study (NCS). I request the release of my baby's Death Certificate to the NCS. I understand that the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (1) prohibits you from releasing my baby's death certificate without my authorization. This form (or a photocopy of this form) gives my authorization to release a copy of my baby's death certificate to the NCS. I understand that the NCS will use this information only for statistical purposes in health research, and no information which identifies me, my baby, my hospitals, my doctors, or other medical care providers will ever be released or published. I also understand that once my baby's death certificate 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 on this form to obtain a copy of my baby's death certificate. 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.</td></tr>
<tr><td>D.</td><td>4.</td><td>____________________
Parent/Guardian's Signature</td><td>5.</td><td>Date Signed ____________________</td></tr>
</table>

(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).