Attachment 11: Authorization to Release Medical Records

Form Approved
OMB No. 0925-0407
Exp. Date xx/xx/20xx

PROSTATE, LUNG, COLORECTAL, AND OVARIAN (PLCO) CANCER SCREENING TRIAL FOLLOW-UP STUDY
CENTRAL DATA COLLECTION CENTER (CDCC)

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION FOR RESEARCH

Participant Name: *<<Participant First Name>> <<Participant Last Name>>*

PID: *<<PID>>* ***Date of Birth:*** *<<Participant DOB>>* ***Gender:*** *<<Participant Gender>>*

Please read this form and provide information listed in this box for the appropriate Medical Provider and/or institution to contact for your medical records.

Name of the doctor who diagnosed this cancer:_____

Name of the Institution where cancer was diagnosed:

Street Address: <<PROVIDER STREET ADDRESS >>

City: <<PROVIDER CITY>> State: <<PRVRSTATE>> Zip Code: <<PRVRZIP>>

Telephone: (<<###>>) <<###>> – <<####>>

Name of the doctor who treated this cancer:_____

Name of the Institution where cancer was treated:

Street Address: <<PROVIDER STREET ADDRESS >>

City: <<PROVIDER CITY>> State: <<PRVRSTATE>> Zip Code: <<PRVRZIP>>
Telephone: (<<###>>) <<###>> – <<####>>

I hereby authorize the above referenced medical provider to release my protected health information, including copies of my medical and hospital records, pathology slides, or tissue blocks related to the diagnosis and treatment of <<TYPE OF CANCER>> cancer to research staff at the Central Data Collection Center (CDCC), Westat, who are working on the study entitled Prostate, Lung, Colorectal and Ovarian (PLCO) Cancer Screening Trial Extended Follow-up Study. This study is being conducted by the National Cancer Institute (NCI). My individual health information that may be used or disclosed includes medical health data, full or abstracted records, slides or tissue blocks released after the date of my signature.

Form Approved
OMB No. 0925-0407
Exp. Date xx/xx/20xx

PROSTATE, LUNG, COLORECTAL, AND OVARIAN (PLCO) CANCER SCREENING TRIAL FOLLOW-UP STUDY
CENTRAL DATA COLLECTION CENTER (CDCC)

(Continued with Signature on page 2)

It is my understanding that this information will be used for research purposes only and no individual will ever be identified in any published report. I understand that I may revoke this authorization at any time with written notification to the Participant Support Coordinator at PLCO CDCC, Westat, 1600 Research Blvd, Room GA-L60, Rockville, Maryland 20850, to inform the research team of my decision, but that the revocation will not have any effect on the information released, used or disclosed, or collected by the study prior to notification of revocation. This authorization does not have an expiration date.

I understand that once my health information is disclosed under this authorization, there is potential for re-disclosure of my medical information and my medical information may not be subject to privacy rule protections; therefore the facility listed above is released from any and all liability resulting from re-disclosure.

I have been informed that I do not have to sign this Authorization. My decision not to sign the Authorization will not affect any other treatment, payment, or enrollment in health plans, cancer research studies, or eligibility for benefits.

A photocopy/fax of this authorization will be treated in the same manner as an original.

I am the research participant or personal representative authorized to act on behalf of the participant. I have read this information and I have received a copy of this authorization form.

_____
(PARTICIPANT'S SIGNATURE)

_____ _____
(**PRINT** PARTICIPANT'S FULL NAME) (DATE)

_____
(PERSONAL REPRESENTATIVE'S SIGNATURE)

_____ _____
(**PRINT** PERSONAL REPRESENTATIVE'S FULL NAME) (DATE)

_____
(Relationship or authority to act on behalf of the participant)

Reason for Personal Representative Signature: ☐ Participant Disabled ☐ Participant Deceased