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To Whom It May Concern:

As part of the research study of the National Heart, Lung and Blood Institute in Framingham, Massachusetts into the causes of coronary disease and stroke, we are interested in completing our records on the person listed below who was in our study and had died within your jurisdiction.

Name: ID#

Date of Death:

Date of Birth:

We would appreciate a copy of the death certificate. The information you provide will be kept confidential, and will not be disclosed to anyone but the researchers conducting this study, except as otherwise required by law.

Please use enclosed return envelope or send reply/information
To Attn: MEDICAL RECORDS DEPARTMENT

Thank you for your kind assistance.

Sincerely yours,

Daniel Levy, M.D.
Medical Director
Framingham Heart Study

DL/lm

Dear Doctor:

As part of the research study of the National Heart, Lung and Blood Institute, the Framingham Heart Program has been studying the causes of coronary disease and stroke for nearly fifty years. We are interested in completing our records on the person listed below who has been a participant in our long-term study.

Patient: ID#

Date of Birth:

Records pertaining to
Date:

We would appreciate copies of the records requested. A return envelope is enclosed for your convenience. The information you provide will be kept confidential, and will not be disclosed to anyone but the researchers conducting this study, except as otherwise required by law.

Please use enclosed return envelope or send reply/information
To: Attn: MEDICAL RECORDS DEPARTMENT

Thank you for your kind assistance in this matter.

Sincerely yours,

Daniel Levy, M.D.
Medical Director
Framingham Heart Study

DL/lm

Dear

As part of the research study of the National Heart, Lung and Blood Institute, the Framingham Heart Program has been studying the causes of coronary heart disease and stroke for over fifty years.

As you know, _____ is a participant in the Heart Study. In order to review his record, we would like permission to obtain copies of his medical record(s) from the following:

Would you be willing to help us by signing the enclosed authorizations(s) and sending a copy of the Power of Attorney/Executor Appointment paper (if available) so that we can obtain the medical record(s).

Please return it to us in the enclosed envelope as soon as possible. The information you provide will be kept confidential, and will not be disclosed to anyone but the researchers conducting this study, except as otherwise required by law. Please use enclosed return envelope or send reply/information to: Attn: MEDICAL RECORDS DEPARTMENT

We will be most grateful for your cooperation.

Sincerely yours,

Daniel Levy, M.D.
Medical Director
Framingham Heart Study

DL/lm
OMB # 0925-0216

TO WHOM IT MAY CONCERN:

I hereby authorize

to release to the Framingham Heart Study
73 Mt Wayte Ave.
Framingham, MA 01702

the following protected health information from
medical record.

Patient Name: _____ Date of Birth: _____
Address: _____

Disclose the following information for dates:

- | | |
|---------------------|---------------------------------|
| * Face Sheet | * CT Scan (Head) |
| * Discharge Summary | * MRI/MRA (Head/Neck) |
| * ER Report | * Lab Reports - Cardiac Enzymes |
| * Admission Notes | * Consults (Cardiac & Neuro) |
| * Progress Notes | * Cardiac Catheterization |
| * Operative Report | * Exercise Tolerance Test |
| * Pathology Report | * Nursing Home Notes |
| * Chest X-Rays | * Notes near time of death |
| * EKGs (All) | * Other _____ |
| * Echocardiogram | _____ |

The purpose for this disclosure is research.

The information disclosed under this authorization
will not be redisclosed to anyone but the researchers
conducting this study, except as required by law.

I understand I may revoke this authorization at any time by
requesting such of the above referenced physician/hospital
in writing. If I do it will not have any effect on actions
that the hospital/physician took before it received the
revocation.

This authorization expires at the end of the research study.

DATE

SIGNED

PRINTED NAME

RELATIONSHIP TO PATIENT OR
AUTHORITY TO ACT FOR PATIENT

To Whom It May Concern:

As part of the research study of the National Heart, Lung and Blood Institute, the Framingham Heart Study has been studying the causes of coronary disease, stroke, cancer and other major diseases for over sixty years. We are interested in completing our records on the person listed below who has been a participant in our long-term study.

Patient:

Id#

Date of Birth:

Date(s):

Records Requested:

<input type="checkbox"/> Face Sheet	<input type="checkbox"/> CT Scans
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> MRI/MRAs
<input type="checkbox"/> ER Report	<input type="checkbox"/> EEG
<input type="checkbox"/> Admission Notes	<input type="checkbox"/> Ultrasound
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Lab Reports - Cardiac Enzymes
<input type="checkbox"/> Operative Reports	<input type="checkbox"/> Consults (Cardiac and Neuro)
<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> Cardiac Catheterization
<input type="checkbox"/> X-Rays	<input type="checkbox"/> Nursing Home Notes
<input type="checkbox"/> Echocardiogram	<input type="checkbox"/> Notes near time of death
<input type="checkbox"/> Exercise Tolerance Test	<input type="checkbox"/> Pronouncement Note
<input type="checkbox"/> EKGs with rhythm tracings graph (all)	

We would appreciate copies of the records requested. A return envelope is enclosed for your convenience. The information you provide will be kept confidential, and will not be disclosed to anyone but the researchers conducting this study, except as otherwise required by law. Please use enclosed return envelope or send reply/information to:
Attn: MEDICAL RECORDS DEPARTMENT

Thank you for your kind assistance in this matter.

Sincerely yours,

Daniel Levy, M.D.
Medical Director
Framingham Heart Study

DL/dc

Dear

As part of the research study of the National Heart, Lung and Blood Institute in Framingham, Massachusetts into the causes of heart disease and stroke, we are interested in updating our records on you. In order to do that we would like to obtain a copy of your medical records from the following:

Could you please help us by signing the authorization form(s) and returning it to us in the enclosed envelope as soon as possible. The information you provide will be kept confidential, and will not be disclosed to anyone but the researchers conducting this study, except as required by law.

Please use enclosed return envelope or send reply information to: Attn: MEDICAL RECORDS DEPARTMENT

We will be most grateful for your cooperation.

Sincerely yours,

Daniel Levy, M.D.
Medical Director
Framingham Heart Study

DL/lm
OMB # 0925-0216

TO WHOM IT MAY CONCERN:

I hereby authorize

to release to the Framingham Heart Study
73 Mt Wayte Ave.
Framingham, MA 01702

the following protected health information from my
medical record.

Patient Name: _____ Date of Birth: _____
Address: _____

Disclose the following information for dates:

- | | |
|---------------------|---------------------------------|
| * Face Sheet | * CT Scan (Head) |
| * Discharge Summary | * MRI/MRA (Head/Neck) |
| * ER Report | * Lab Reports - Cardiac Enzymes |
| * Admission Notes | * Consults (Cardiac & Neuro) |
| * Progress Notes | * Cardiac Catheterization |
| * Operative Report | * Exercise Tolerance Test |
| * Pathology Report | * Nursing Home Notes |
| * Chest X-Rays | * Notes near time of death |
| * EKGs (All) | * Other _____ |
| * Echocardiogram | _____ |

The purpose for this disclosure is research.

The information disclosed under this authorization
will not be redisclosed to anyone but the researchers
conducting this study, except as required by law.

I understand I may revoke this authorization at any time by
requesting such of the above referenced physician/hospital
in writing. If I do it will not have any effect on actions
that the hospital/physician took before it received the
revocation.

This authorization expires at the end of the research study.

DATE: _____ SIGNED: _____

OMB # 0925-0216

E

Dear

Please accept our most sincere condolences on the death of . We at the Framingham Heart Study appreciate her dedication to our research.

As part of the research study of the National Heart, Lung and Blood Institute, the Framingham Heart Study has been studying the causes of coronary disease, stroke, cancer and other major diseases for over sixty years.

In order to review her record, we would like permission to obtain copies of medical record(s) from the following:

Would you be willing to help us by signing the enclosed authorizations(s) **and sending a copy of the Power of Attorney/ Executor Appointment papers** (if available) so that we can obtain the medical record(s).

Please return it to us in the enclosed envelope at your earliest convenience. The information you provide will be kept confidential, and will not be disclosed to anyone but the researchers conducting this study, except as otherwise required by law. Please use enclosed return envelope or send reply/information to: Attn: MEDICAL RECORDS DEPARTMENT

Again, we offer our sincere condolences and are grateful for your cooperation.

Sincerely yours,

Daniel Levy, M.D.
Medical Director
Framingham Heart Study

DL/lm

TO WHOM IT MAY CONCERN:

I hereby authorize
to release to the Framingham Heart Study
73 Mt Wayte Ave.
Framingham, MA 01702

the following protected health information from
medical record.

Patient Name: _____ Date of Birth: _____
Address: _____

Disclose the following information for dates:

- | | |
|---------------------|---------------------------------|
| * Face Sheet | * CT Scan(s) |
| * Discharge Summary | * MRI/MRA(s) |
| * ER Report | * Lab Reports - Cardiac Enzymes |
| * Admission Notes | * Consults (Cardiac & Neuro) |
| * Progress Notes | * Cardiac Catheterization |
| * Operative Report | * Exercise Tolerance Test |
| * Pathology Report | * Carotid Ultrasound |
| * Chest X-Rays | * EEG |
| * EKGs (All) | * Nursing Home Notes |
| * Echocardiogram | * Notes near time of death |
| * Holter Monitor | * Pronouncement Note |
| * Other _____ | |

The purpose for this disclosure is research.

The information disclosed under this authorization **will not be redisclosed** to anyone but the researchers conducting this study, except as required by law.

I understand I may revoke this authorization at any time by requesting such of the above referenced physician/hospital in writing. If I do it will not have any effect on actions that the hospital/physician took before it received the revocation.

This authorization expires at the end of the research study.

_____ DATE	_____ SIGNED
_____ PRINTED NAME	_____ RELATIONSHIP TO PATIENT OR AUTHORITY TO ACT FOR PATIENT