OMB Control Number: 0925-0216 Expiration Date: 10/2016

Public reporting burden for this collection of information is estimated to average 15 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: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0216). Do not return the completed form to this address.

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

To Whom It May Concern:

I hereby authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

to release to the Framingham Heart Study

 73 Mt. Wayte Avenue

 Framingham, MA 01702

The following protected health information my medical record.

Patient Name: Date of Birth:

Address:

 ,

Disclose the following information for dates from to present.

|  |  |
| --- | --- |
| * 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-Ray
 | * Notes near time of death
 |
| * EKGs (All)
 | * Pronouncement Note
 |
| * 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 of Death:

 Date(s):

 Records Requested:

 \_\_\_Face Sheet \_\_\_CT Scans

 \_\_\_Discharge Summary \_\_\_MRI/MRAs

 \_\_\_ER Report \_\_\_EEG

 \_\_\_Admission Notes \_\_\_Ultrasound

 \_\_\_Progress Notes \_\_\_Lab Reports ‑ Cardiac Enzymes

 \_\_\_Operative Reports \_\_\_Consults (Cardiac and Neuro)

 \_\_\_Pathology Reports \_\_\_Cardiac Catheterization

 \_\_\_X‑Rays \_\_\_Nursing Home Notes

 \_\_\_Echocardiogram \_\_\_Notes near time of death

 \_\_\_Exercise Tolerance Test \_\_\_Pronouncement Note

 \_\_\_**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

 Xxxx Xxxxx

 000 Xxxx Xx.

 Xxxxxxx, XX 00000

 Dear Xxxx Xxxxx,

 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 sixty years.

 As you know, Xxxxxx Xxx was a participant

 in the Heart Study. In order to review her record, we would

 like permission to obtain copies of her medical record(s)

 from the following:

 Xxxxxxx Xxxxxxxx.

 Would you be willing to help us by signing the enclosed

 authorizations(s) 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 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

TO WHOM IT MAY CONERN:

I hereby authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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This authorization expires at the end of the research study.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRINTED NAME RELATIONSHIP TO PATIENT OR

 AUTHORITY TO ACT FOR PATIENT