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

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: «FName» «MName» «LName» Date of Birth: «DOB»
Address: «Str1»
«Str2»
«City», «State» «Zip»

Disclose the following information for dates from «Evdate» to present.

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

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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to release to the Framingham Heart Study
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Framingham, MA 01702

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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