

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:            «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

Discharge Summary

ER Report

Admission Notes

Progress Notes

CT Scans

MRI/MRAs

EEG

Ultrasound

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

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: \_\_\_\_\_

\_\_\_\_\_  
PRINTED NAME

\_\_\_\_\_  
RELATIONSHIP TO PATIENT OR  
AUTHORITY TO ACT FOR PATIENT