DIAMOND BLACKFAN ANEMIA REGISTRY

Pediatric Hematology/Oncology and Stem Cell Transplantation
Cohen Children's Medical Center
Office: (516) 562-1504 Fax: (516) 562-1599

Dear Parent/Patient,

Please fill in the information and sign your name below.

CONSENT TO OBTAIN MEDICAL RECORDS

Patient Name:_____
Last Name **First Name**

Date of Birth: ____/____/_____
Month Day Year

Name of Patient's Physician: _____
Last Name **First name**
Address: _____
City: _____ **State:** _____ **Zip:** _____

Phone Number: (____)_____ Fax Number: (____)_____(if available)

I hereby authorize you to send all medical information regarding the above patient to:

Diamond Blackfan Anemia Registry
Division of Pediatric Hematology/Oncology
The Feinstein Institute for Medical Research
350 Community Drive, Room 3146
Manhasset, NY 11030
Fax: 516-562-1599

Information to be released:

Please check all that apply

O Clinic notes	O Hospital discharge summary	O Laboratory records	O Radiology reports
O History and Physical	O EKG's	O Operative reports	O Radiology images
O Hospital Notes	O Immunization records	O Pathology reports	

O Other (please specify)_____

I understand the information to be released may include records related to behavior and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS, and genetics. This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. Revocation must be made in writing to the provider/facility releasing the information. The provider/facility will not condition treatment on whether I sign the authorization. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal law.

SIGNATURE: _____ **Date :** _____
Patient /Parent or Guardian
Printed Name of Person Signing _____

Address: _____
City: _____ **State:** _____ **Zip:** _____
Phone Number: _____

Thank you for your prompt attention to this matter