CONSENT TO DISCLOSE HEALTH/REGISTRATION INFORMATION

This form documents an individual’s consent to disclose personally identifying health or registration information in compliance with Section 34 of the *Health Information Act*. It is to be completed in full by the participant before the disclosure, presented to the custodian, and filed as part of the participant’s records. Please be sure to put your letterhead on this document and complete the highlighted portions below:

1. Leave the name of the custodian blank as it will be filled in when you request the participant’s health information.
2. List specific information that you will be requesting from the custodian.
3. Insert the Investigator name.
4. State purpose of collecting the participant’s health information.
5. Insert the full protocol title and number.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize *1. Insert name of Custodian of health information* to disclose the following individually identifying health information *(2. state specific information required*) to *(3. Insert name of Study Doctor and/or his research associates)* in order to *(4. state purpose):*

I agree to release this information for the purposes of the (*5. state full research project title)* and understand that no individually identifying health information will be used in the study database or in publication.

I understand why this health information is needed and the risks and benefits to me of consenting or refusing to consent to allow the disclosure of this information. I also understand that I may revoke this consent any time.

This consent is effective today, as per my dated signature below, and continues until my participation in the study ends.

Participant’s Name Witness Name

Participant’s Signature Witness Signature

Date Date