Authorization for Release of Medical Records

Please complete and mail to: The UNC Alumni Heart Study, PO Box 61788, Durham, NC 27705 or FAX to (919) 681-8960

Name _____ (Last, First, Middle/Maiden)

Last 4 digits of your Social Security # _____ **Date of Birth** _____ **Study ID#** _____

Request for Release of Information: I request and authorize the following health care provider *(Please provide name and address of the institution from which we will be requesting medical records here)*:

to release my medical records (as described below) to the UNC Alumni Heart Study (UNCAHS) investigators and their study staff. The purpose for this authorization is to allow my medical records to be used in the UNCAHS, an Institutional Review Board (IRB) approved research study being conducted by Dr. Ilene C. Siegler, of which I am a participant. My records should be sent to the attention of Dr. Ilene C. Siegler, PO box 61788, Durham, NC 27705, for use in conducting the research study.

Medical Records To Be Disclosed: This authorization permits the institution listed above to disclose all medical records related to the following events and procedures:

			Records requested:
Heart Attack/MI	YES _____	Date(s) _____	Enzymes report, Discharge summary
Stroke (not TIA)	YES _____	Date(s) _____	Discharge summary
CAD/Coronary Artery Disease	YES _____	Date(s) _____	Any related records
Heart Catheterization/Angiography *(please include even if normal)*	YES _____	Date(s) _____	Operative/Cath. report, Discharge summary
Angioplasty/PTCA/Stent placement	YES _____	Date(s) _____	Operative report, Discharge summary
Bypass surgery/CABG	YES _____	Date(s) _____	Operative report, Discharge summary

Limits of this Authorization: I understand that my medical records/health information will be used and shared with others to carry out this research study and as required by law. I understand that while every effort will be made to protect this information, absolute privacy and confidentiality cannot be guaranteed. I further understand that if the person or entity receiving this information is not covered by federal privacy regulations, the information may be redisclosed and will no longer be protected by these regulations. **Term of this Authorization:** This authorization will remain in effect until the end of the UNCAHS and I will not be able to obtain my research records until then. **Refusal to sign/Right to Revocation:** I understand that I may refuse to sign this Authorization for any reason and that such refusal will not affect my eligibility to participate in this research study. In addition, I may change my mind and revoke (e.g., withdrawal or cancel) this authorization at any time by writing the Principal Investigator of the study. This letter can be sent to Dr. Ilene C. Siegler, PO Box 61788, Durham, NC 27705. However, I understand that even if I revoke this authorization, my health information and medical records already obtained by the UNCAHS may still be used and shared as necessary to maintain the integrity of the research study. **Questions:** I may contact the Principal Investigator named above for answers to my questions about the privacy of my health information. She can be reached at 1-800-233-5912.

Signature: _____ **Date:** _____

If the participant is unable to sign, I am the Legally Authorized Representative and have the authority to sign this form.

Name:_____ Legal Relationship_____ Date _____