The Children's Hospital of Philadelphia
Clinical Genetics Center
34th Street and Civic Center Boulevard, Philadelphia, PA 19104-4399
Phone (267)-425-2467
Fax (267)-425-0007

REQUEST FOR MEDICAL INFORMATION/SAMPLES

Please return this form for your records.

Name of Institution, Practice, or Agency_____

Physician or medical staff_____

Address_____

Phone_____ Fax_____

This patient has been enrolled in a study being conducted by Dr. Jennifer Kalish and her colleagues. We would like to obtain as much clinical information as possible to understand their medical conditions. We would also like to collect samples left over from procedures (for example following surgical procedures or blood draws). Please forward medical records, laboratory and imaging studies (in digital format if possible) to:

Mail: Attn: Jennifer Kalish, MD PhD
Division of Human Genetics
3028 Colket Translational Research Building
3501 Civic Center Blvd
Philadelphia, PA 19104
Fax: (267) 425-0007
Or Scan and email to: GEAregistry@chop.edu
If there are any questions, please feel free to contact me at the email address above or at 267-425-2467.

Patient's Name_____ Date of Birth_____

Mother's Name_____ Father's Name_____

Address_____

Information to be Released: ☐ Inpatient ☐ Outpatient ☐ Genetics Records/Testing Results

☐ Other:_____

Expiration. Your permission will expire 1 year after you sign this form unless you indicate otherwise.

I hereby authorize The Children's Hospital of Philadelphia to obtain my child's medical records with respect to any illness, injury, medical history, consultation, or treatment. I authorize the release of surgical or other samples.

This allows the release or obtaining of information that exists in the patient's medical record when the form is signed, as well as information created after the form is signed until it expires.

I may withdraw my permission at any time by providing written notice to the above-named provider releasing the information. For information being released by The Children's Hospital of Philadelphia, see its *Notice of Privacy Practices* for instructions on how to withdraw (revoke) an authorization. If I withdraw my permission, any information that was already released cannot be retrieved.

_____ _____ _____
Signature Print Name Date

Relationship to patient: ☐ Patient ☐ Parent ☐ Legal Guardian ☐ Other_____

_____ _____
Jennifer M. Kalish, MD, PhD Attending Physician

Children's Hospital of Philadelphia
RESEARCH INSTITUTE