



The Children's Hospital of Philadelphia

34th Street and Civic Center Boulevard, Philadelphia, PA 19104-4399

Clinical Genetics Center

Phone 215-590-2920

Fax 215-590-3298

REQUEST FOR MEDICAL INFORMATION/SAMPLES

Please return this form with 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: (215) 590-3298

Or Scan and email to: kalishj@email.chop.edu

If there are any questions, please feel free to contact me at the email address above or at (203) 676-5283.

Patient's Name _____ Date of Birth: _____

Mother's Name _____ Father's Name _____

Address _____

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

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