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Cambridge, MA 02142
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Medical Release Form – Self (Osteosarcoma Project)

Thank you very much for your consent to participate in this research study. To proceed with our study, we have asked you for information about:

1. Your contact information, including your current mailing address, so that we can send you a saliva kit
2. The name and contact information for the physician(s) who has/have cared for you throughout your experiences with Osteosarcoma cancer, so we can obtain copies of your medical records
3. The names of the hospitals / institutions where you've had biopsies and surgeries, so we can obtain some of your stored tumor samples, if elected on the informed consent

Printed below is the information you have provided to us:

YOUR CONTACT INFORMATION

First Name: **Last Name:**

Street Address:

City: **State:**

Zip: **Country:**

Phone: