



**BROAD**  
INSTITUTE



**Dana-Farber**  
Cancer Institute



Count  
Me  
In

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**By completing this information, you are agreeing to allow us to contact these physician(s) and hospital(s) / institution(s) to obtain your child's records.**

I have already read and signed the informed consent document for this study, which describes the use of my child's personal health information (Section O: Authorization to use your health information for research purposes), and hereby grant permission to Nikhil Wagle, MD, Dana-Farber Cancer Institute, 450 Brookline Ave, Boston, MA, 02215, or a member of the study team to examine copies of my child's medical records pertaining to my child's cancer diagnosis and treatment, and, if I elected on the informed consent document, to obtain tumor tissue and/or blood samples for research studies. I acknowledge that a copy of this completed form will be accessible via my project account.

**Full Name:**

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**Date (mm/dd/yyyy):**

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