415 Main Street
Cambridge, MA 02142
T 617-714-7000
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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 records.

I have already read and signed the informed consent document for this study, which describes the use of my 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 medical records pertaining to my cancer diagnosis and treatment, and, if I elected on the informed consent document, to obtain tumor samples 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:

Date (mm/dd/yyyy):