415 Main Street
Cambridge, MA 02142
T 617-714-7000
www.joincountmein.org

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), 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 brain 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:

Date (mm/dd/yyyy):