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

Medical Release Form – Parent or Guardian
(Brain Cancer Project)

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

1. Your contact information, including your child's current mailing address, so that we can send y o u a kit to collect your child's saliva
2. The name and contact information for the physician(s) who has/have cared for your child throughout your child's experiences with Brain Cancer, so we can obtain copies of your child's medical records
3. The names of the hospitals / institutions where your child had biopsies and surgeries, so we can obtain some of your child's 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:**

YOUR CHILD'S MAILING ADDRESS

Street Address:

City: **State:**

Zip: **Country:**

Phone: