



Medical Release Form – Self (Leiomyosarcoma Project)

Thank you for your consent to participate in this research study.

To complete the process and proceed with this study, we will need to collect some additional information from you below about the following:

- The name(s) and information for the physician(s) who has/have cared for you throughout your experiences with cancer.
- The names of the hospitals / institutions where you have received treatment or have had procedures performed (e.g. biopsies and/or surgeries).

We may use this information to obtain copies of your medical records, and if you had elected on the informed consent, we may also obtain some of your stored tumor samples.

Below, please share all of the places where you have received care for your cancer(s), including:

- Institutions where you have **received treatment**.
- Institutions where you have had **procedures** (e.g. biopsies and/or surgeries) or **imaging** (e.g. MRI scans, X-rays, CAT/CT scans, PET/SPECT scans, and/or ultrasounds) performed.