415 Main Street
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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), 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 angiosarcoma diagnosis and treatment, and, if I elected on the informed consent document, to obtain tumor tissue for research studies. I acknowledge that a copy of this completed form will be sent to my email address.**

_____ _____

Full Name **Date**

_____

Date of Birth