I understand and agree that:

1. This authorization is voluntary.
2. By completing this information, you are agreeing to allow us to contact these physician(s) and hospital(s)/institutions(s) to obtain and store your records.
3. My treatment, payment, health plan enrollment, or eligibility for benefits will not be affected if I do not sign this form.
4. I may cancel this authorization at any time by submitting a written request to the study staff, except if Link My Heart has already relied upon it (for example, once information is released, it will not be retrieved).
5. I understand that access to my medical records may include access to my previous genetic testing results.
6. My questions about this authorization form have been answered.
7. I have already read and signed the informed consent document for this study, which describes the use of my personal health information, and hereby grant permission to Patrick Ellinor, MD, PhD, and/or members of the study team to examine copies of my medical records pertaining to my Brugada syndrome diagnosis and other related conditions. I acknowledge that I can access a copy of this completed form on my dashboard on the study website at brugada.linkmyheart.org.

Full Name:

DOB:

Date
