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# Medical Release Form – Self
# (Brain Cancer Project)

**Thank you very much for your consent to participate in this research study. To complete the process, we will need to collect some additional information from you below:**

**To proceed with this study, we need to collect information about:**

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

**Street Address:** _____

**City:**_____ **State:**_____ **Zip:** _____ **Country:** _____

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**Phone:** _____

**YOUR PHYSICIANS' NAMES:**

**Physician Name:** _____

**Institution (if any):** _____

**City:** _____ **State:** _____

**YOUR INITIAL BIOPSY HOSPITAL / INSTITUTION NAME:**

**Institution:** _____

**City:** **State:**

**YOUR HOSPITAL/INSTITUTION NAMES?**

**Institution:** _____

**City:** **State:**

**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 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.**

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**Full Name** _____ **Date** _____

**Date of Birth** _____

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# Medical Release Form – Parent or Guardian

Thank you very much for your consent to have your child participate in this research study. To complete the process, we will need to collect some additional information from you below:

To proceed with this study, we need to collect information about:

1. Your contact information, including your child's current mailing address, so that we can send you 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: _____

YOUR CHILD'S PHYSICIANS' NAMES:

Physician Name: _____

Institution (if any): _____

City:_____ State:_____

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YOUR CHILD'S INITIAL BIOPSY HOSPITAL / INSTITUTION NAME:

Institution: _____

City: State:

YOUR CHILD'S HOSPITAL/INSTITUTION NAMES?

Institution: _____

City: State:

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