415 Main Street
Cambridge, MA 02142
T 651-403-5315
www.joincountmein.org

Medical Release Form (Count Me In)

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 cancer samples.

Below, please share all of the places where you have received care for your cancer(s), including any institutions where you have received treatment or have had procedures performed (e.g. biopsies and/or surgeries) for your cancer:

Physician Name (if applicable):
Hospital/Institution (if any):
City:
State:
Country:

[BUTTON] Add another hospital/institution

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: Authorization to use your health information for research purposes), and hereby grant permission to Nikhil Wagle, MD, Dana-Farber Cancer Institute, 450 Brookline Ave, Boston, MA, 02215, or a

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member of the study team to examine copies of my medical records pertaining to my cancer diagnosis and treatment, and, if I elected on the informed consent document, to obtain cancer samples 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 _____

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Medical Release Form – Parent or Guardian (Count Me In)

Thank you for your consent to have your child 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 your child throughout your child's experiences with cancer
- The names of the hospitals / institutions where your child has received treatment or has had procedures performed (e.g. biopsies and/or surgeries)

We may use this information to obtain copies of your child's medical records, and if you have elected on the informed consent, we may also obtain some of your child's stored cancer samples.

Below, please share all of the places where your child has received care for their cancer(s), including any institutions where your child has received treatment or has had procedures performed (e.g. biopsies and/or surgeries) for their cancer:

Physician Name (if applicable):
Hospital/Institution (if any):
City:
State:
Country:

[BUTTON] Add another hospital/institution

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: Authorization to

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use your child's health information for research purposes), 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 cancer diagnosis and treatment, and, if I elected on the informed consent document, to obtain my child's cancer samples 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 _____