415 Main Street
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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 angiosarcoma, 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**

Printed below is the information you have provided to us:

YOUR CONTACT INFORMATION:

First Name: In

Last Name: Flames

Current Mailing Address: 415 Main Street

City: Cambridge **State:** MA **Zip:** 02142 **Country:** US

Phone: 1234567890

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Cambridge, MA 02142
T 617-714-7000
www.broadinstitute.org

YOUR PHYSICIANS' NAMES:

Physician Name: can't remember

Institution (if any): the one next door

City: Cambridge **State:** MA

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Cambridge, MA 02142
T 617-714-7000
www.broadinstitute.org

YOUR PHYSICIANS' NAMES:

Physician Name: _____

Institution (if any): next to the next door one

City: Boston **State:** _____

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YOUR PHYSICIANS' NAMES:

Physician Name: really nice guy

Institution (if any): _____

City: Florida **State:** _____

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YOUR PHYSICIANS' NAMES:

Physician Name: not you _____

Institution (if any): _____

City:_____ **State:**_____

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YOUR PHYSICIANS' NAMES:

Physician Name: last one

Institution (if any): around the corner

City: Seattle **State:**

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YOUR INITIAL BIOPSY HOSPITAL / INSTITUTION NAME:

Institution: big big hospital

City: Boston **State:**

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Cambridge, MA 02142
T 617-714-7000
www.broadinstitute.org

YOUR HOSPITAL / INSTITUTION NAMES:

Institution: smaller hospital

City: Cambridge **State:** MA

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T 617-714-7000
www.broadinstitute.org

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.**

In Flames

Full Name

02-08-2017

Date

01-01-1988

Date of Birth