# MEDICAL RECORDS RELEASE FORM

***AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION***

**Christopher A. Walsh, MD, PhD**
Chief, Division of Genetics and Genomics
Howard Hughes Medical Institute
Boston Children's Hospital

1. I authorize _____ to use/disclose the requested protected health information from the medical records of the patient listed below. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

   ***Name of hospital/physician***

2. Patient name: _____ Date of Birth: _____

   Address: _____ _____

   ***Street*** ***City*** ***State/Province*** ***Zip/Postal Code***

3. Information to be disclosed and sent to:

   Dr. Christopher Walsh, c/o Abbe Lai/Jennifer Neil
   Walsh Lab, Division of Genetics and Genomics Boston Children's Hospital, BCH3150
   300 Longwood Avenue
   Boston, MA 02115 USA
   Phone: 617-919-4795 | Fax: 617-919-2300

4. Please disclose the following information (check all that apply):

   ☐ **Medical Records** (Neurology & Genetics Test Results & Visits) for dates _____ to _____

   ☐ **Brain MRI Films** for dates _____ to _____

   ☐ **Other** _____

5. The above information is disclosed for the purpose of research.

6. I understand I may revoke this authorization at any time by requesting such of the above referenced hospital/physician in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law.

7. This authorization expires one year from date signed unless noted otherwise: _____

8. Signatures:

_____ _____

***Signature of Patient or Guardian*** ***Date***

_____ _____

***Printed name of Patient or Guardian*** ***Relationship to patient/authority to act for patient***

**INSTRUCTIONS**

Line #1: Enter the name of the physician, hospital or institution from which specific records are being requested. You may need to make copies of this form if you are requesting records from multiple locations.
Line #2: Enter the address *at the time the person was seen for care.*
Line #4: Please check the appropriate records you are requesting from the facility; the dates need not be exact but a rough estimate is helpful.
Line #8: Sign, date and print your name at the bottom of the form.

**>>>> PLEASE DO NOT SEND THIS FORM TO THE WALSH LAB <<<<**

**Please send completed form(s) directly to the physician or institution from which records are being requested.**

Your records will be copied and sent to Dr. Walsh. Please contact us with questions or to check the status of records being received into the lab at the address above or by email at: **walshresearch@childrens.harvard.edu**