

RELEASE AUTHORIZATION

TO: NWTS Data and Statistical Center
Fred Hutchinson Cancer Research Center
1100 Fairview Avenue N M2-A876
P.O. Box 19024
Seattle, WA 98109
Telephone: (206) 667-4842, Fax: (206) 667-6623

FROM:

RE: Patient Name: _____ Patient ID #: _____
Birth date: _____ Last 4 digits of Social Security # (Optional): _____

I, _____, MD, authorize the NWTS Data and Statistical Center to contact all persons listed in order to secure information about the health status of the patient named above.

Signature required: _____ **Date:** _____

PLEASE PROVIDE ALL AVAILABLE NAMES AND ADDRESSES

This form is only to be used for participants already registered and consented to the Late Effects Study 4941L/9442.

*Please have your CRA, data manager or tumor registrar complete this form. Any information, even if **old**, can be vital to the tracking process. Thank you.*

PARENT, GUARDIAN OR ADULT PATIENT

I. PARENTS	FATHER or Guardian 1	MOTHER or Guardian 2
1. Name	1. _____	1. _____ (Maiden name and other names)
2. Last 4 digits of Social Security# (Optional)	2. _____	2. _____
3. Address	3. _____ (Street) _____ (City,State,Zip Code)	3. _____ (Street) _____ (City,State,Zip Code)
4. Phone	4. () _____	4. () _____
5. Employer	5. _____ (Name/type of business) () _____ (Business Phone)	5. _____ (Name/type of business) () _____ (Business Phone)

II. PATIENT CONTACT INFORMATION IF DIFFERENT FROM PARENT OR GUARDIAN:

1. Home Address: _____ Phone #: () _____

III. ADDITIONAL KNOWN CONTACTS:

1. Name: _____	Relationship to Patient _____
Address: _____	Phone #: () _____
2. Name: _____	Relationship to Patient _____
Address: _____	Phone #: () _____
3. Name: _____	Relationship to Patient _____
Address: _____	Phone #: () _____

THIS INFORMATION WILL BE KEPT IN STRICTEST CONFIDENCE AND WILL NOT BE RELEASED TO ANYONE NOT DIRECTLY INVOLVED IN THIS STUDY

(PLEASE COMPLETE BOTH SIDES)

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Patient Name: _____ Patient ID #: _____

CURRENT PHYSICIAN

(Name)

(Street Address)

(City, State, Zip Code) (_____) (Phone Number)

TUMOR REGISTRAR

(Name)

(Street Address)

(City, State, Zip Code) (_____) (Phone Number)

ADMITTING HOSPITAL AT INITIAL DIAGNOSIS

(Name)

(Street Address)

(City, State, Zip Code) (_____) (Phone Number)

IS THERE ADDITIONAL INFORMATION YOU CAN PROVIDE?

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(PLEASE COMPLETE BOTH SIDES)