RELEASE AUTHORIZATION

TO: NWTS Data and Statistical Center **FROM:**

Fred Hutchinson Cancer Research Center
1100 Fairview Avenue N M2-B230
P.O. Box 19024
Seattle, WA 98109
Telephone: (206) 667-4842, Fax: (206) 667-6623

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)