



hospital where  
your most recent  
biopsy is located

**AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF MEDICAL INFORMATION**

Please **REQUEST** Medical Information **FROM:**

Please **SEND** Medical Information **To:**

\_\_\_\_\_  
*Name of Health Care Provider*

\_\_\_\_\_  
*Name of Person or Entity to Receive Information*

\_\_\_\_\_  
*Name of Medical Office/Hospital*

\_\_\_\_\_  
*Title (Physician, Therapist, Attorney)*

\_\_\_\_\_  
*Street Address*

\_\_\_\_\_  
*Street Address*

\_\_\_\_\_  
*City, State and Zip Code*

\_\_\_\_\_  
*City, State and Zip Code*

I HEREBY AUTHORIZE \_\_\_\_\_ TO RELEASE AND/OR DISCLOSE THE MEDICAL INFORMATION AS INDICATED BELOW TO THE HEALTH CARE PROVIDER, ENTITY, OR PERSON I HAVE INDICATED ABOVE.

RELEASE AND/OR DISCLOSE RECORDS AND INFORMATION REGARDING:

\_\_\_\_\_  
*Name of Patient (List other Names used)*

\_\_\_\_\_  
*Medical Record Number*

\_\_\_\_\_  
*Date of Birth*

\_\_\_\_\_  
*Address*

\_\_\_\_\_  
*City*

\_\_\_\_\_  
*State*

\_\_\_\_\_  
*Zip Code*

\_\_\_\_\_  
*Telephone Number*

**DURATION:** This authorization shall become effective immediately and shall remain in effect until \_\_\_\_\_ (enter date) or for two years from the date of the signature if no date entered.

**REVOCATION:** This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

**REDISCLOSURE:** I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

**SPECIFY RECORDS** Check the box and initial which type of information is to be released and/or disclosed:

**TO BE RELEASED**  General Medical Information (from \_\_\_\_\_ to \_\_\_\_\_)

**AND/OR DISCLOSED:**  Information Regarding Treatment (from \_\_\_\_\_ to \_\_\_\_\_)

Pathology Reports  Laboratory Results

Tumor Block  Frozen Tumor Sample

Other (specify) \_\_\_\_\_

I REQUEST THAT THE HEALTH INFORMATION RELEASED AND/OR DISCLOSED PURSUANT TO THIS AUTHORIZATION BE USED FOR MOLECULAR DIAGNOSTIC PROCEDURES INCLUDING IMMUNOHISTOCHEMISTRY, GENE AMPLIFICATION AND MUTATIONAL ANALYSES, AND MICROARRAY.

A COPY OF THIS AUTHORIZATION IS VALID AS AN ORIGINAL.  
I HAVE THE RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION. THE COPY IS FOR ME TO KEEP.

3/1/11  
Date: \_\_\_\_\_

Signature of Patient or Patient's Representative: \_\_\_\_\_

\_\_\_\_\_  
Indicate Relationship (if Signed by Other than Patient)

Clarity Foundation will keep your personal information and may follow you over your life for information on your cancer and response to treatments. The scientific results about your tissue samples and the clinical information about your case that you wish to share, including the updates that you provide to The Clarity Foundation will be placed into the database. This type of information may include your type of ovarian cancer, the types of chemotherapy you have received and the length of your response to each chemotherapy agent. You do not have to give The Clarity Foundation permission to enter the scientific information about your tissue samples. If you say "No" you can still have the testing procedures done. However, if you say "Yes" now, but later change your mind, The Clarity Foundation will not be able to remove the scientific information from the public database but we will not contact you anymore once you withdraw your consent (change your mind).

Mark your choice by placing your initials in the "Yes" or "No" box below. If you have any questions you can talk to your doctor or the staff at the Clarity Foundation.

The information about the chemical and genetic makeup of my tissue samples may be placed in the public database to be used by researchers and doctors to learn more about cancer and other diseases. I understand my personal information will not be placed in the public database.

YES <u>    LL    </u>
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NO <u>                    </u>
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### **Consent**

You may take as much time as you like before making a decision to have the testing, and you may wish to discuss the testing with your family, friends or family doctor.

I have read and been given a copy of   3   pages of this form. I understand the information provided and my questions have been answered. I agree to have my tissue samples tested.

  Liz Lemon          3/1/11                              
Name of Patient      Date      Signature

  Jack Donaghy          3/1/11                              
Witness      Date      Signature