BRIGHAM AND
WOMEN'S HOSPITAL

HARVARD
MEDICAL SCHOOL

Department of Medicine
181 Longwood Avenue
Boston, Massachusetts 02215-5804
Tel: 617 525-2279

Nurses' Health Study

Throughout the decades that you have participated in the Nurses' Health Study you have provided a wealth of information about your health and lifestyle. The exceptional value of this information is diminished if we lose touch with you later in life. Therefore it is of **great importance** that we are able to receive updated information in the event of an incapacitating illness or death. We have created this form at the request of many nurses in the study.

Completing the attached *Authorization for Release of Medical Records* will make your wishes known in the event that you are not able to personally notify the Nurses' Health Study about changes in your health status.

INSTRUCTIONS

1. **On the reverse side of this page, please complete each field. Make sure you SIGN and date the form.**

2. **Place the completed form with your Will or other personal papers. *DO NOT* return this form to the Nurses' Health Study at this time.**

   You may also wish to make copies of the completed form to give to:

   →Your primary healthcare provider for his/her records

   →Family members who may be able to assist in providing information to the study if an event occurs which precludes your contacting us personally

   →Anyone else who could help the study in the future by providing information or permission.

If you report a new diagnosis of disease to the Nurses' Health Study in the future, in most cases we will mail you a new release form to sign, specific to that diagnosis. It is our intent that the release form on the other side of this sheet will only be used in the event you are unable to personally authorize release of your records.

Additional blank copies of this form are available on-line at www.NursesHealthStudy.org

Nurses' Health Study
Authorization for Release of Medical Records

It is my wish that the Nurses' Health Study be informed in the event of my incapacitation or death.

I hereby grant permission to Walter Willett, MD, Heather Elliason, Sc.D., Meir Stampfer, MD, Harvard University, Channing Laboratory, 181 Longwood Ave., Boston, MA 02115, to examine pertinent medical records or specimens relating to my diagnosis of serious medical conditions or death. Records will remain strictly confidential and used for medical statistical purposes only.

Name (please print): _____

Signature: _____ Birth date: ___/___/_____

Social Security Number: _____-_____-_____ (*optional*)

Date signed: _____/_____/_____ This authorization shall remain in effect without expiration, unless revoked in writing by the patient.

Primary Physician's Name or Hospital: _____

Address: _____

City:_____ State: _____ Zip: _____

Please send pertinent medical records or death certificate along with this form to:

Nurses' Health Study
Attention: Disease Follow-up
181 Longwood Avenue
Boston, MA 02115-5804

For questions: Phone: 617-525-2279
E-mail: nhs@channing.harvard.edu

PLEASE PLACE THIS COMPLETED FORM WITH YOUR WILL OR OTHER PERSONAL PAPERS