

Authorization to RELEASE Patient Health Information
(“Med Release form”)
Managing RAP Research Study
A Children’s Hospital & Regional Medical Center
& University of Washington Joint Research Project

This release form allows your health care provider to release your child’s medical information to researchers to determine whether your child is eligible to take part in a study on Managing Recurrent Abdominal Pain (RAP). Sign this form only if you are interested in having your child evaluated for a research study. Signing this form does not enroll you and your child in the study. If your child is found to be eligible to take part, you will choose whether to take part. Signing this form also indicates that you give permission for researchers to contact you so they may tell you more about the study and ask you some questions to see if your child is eligible. You can contact the Research Project Director, at (206) 616-2358 at any time with questions or to get more information about the study and study participation.

Authorization to RELEASE Patient Health Information

I authorize _____ (name of health care provider) to RELEASE information from the records of:

PATIENT NAME: _____

DATE OF BIRTH: _____ MEDICAL RECORD NUMBER: _____

INFORMATION TO BE DISCLOSED: Medical information (described below)

Dates of service to be disclosed: From ____/____/____ to ____/____/____

Information to be disclosed includes: any or all patient medical records information that is considered relevant for the screening of medical eligibility for enrollment in the Managing RAP study. Medical information considered relevant for medical eligibility screening typically includes records such as: physical examination, growth, and basic laboratory testing including urine and blood tests. The information released may include records regarding mental health treatment and medical prescriptions.

RELEASE INFORMATION TO: Study personnel for the Managing RAP study (listed below). These are the research team members. Only these persons will review your child’s protected health information to determine eligibility. They are required to protect the privacy of your child’s health information.

- Rona Levy, MSW, PhD, MPH, Principal Investigator, University of Washington, School of Social Work, 206-543-5917
- Dennis Christie, MD, Co-Investigator, Children’s Hospital and Regional Medical Center, 206-526-2521
- Shelby Langer, PhD, Project Director, School of Social Work, University of Washington, 206-616-2358
- Melissa Young, Clinical Research Associate, Children’s Hospital and Regional Medical Center, 206-987-1037
- Keri LaRocque, Clinical Research Associate, Children’s Hospital and Regional Medical Center, 206-987-7872
- Sarah McDonald, Program Coordinator, School of Social Work, University of Washington, 206-616-2358

PURPOSE FOR RELEASE: To determine whether your child is eligible to participate in the Managing Recurrent Abdominal Pain (RAP) study.

These records may contain information relating to behavioral or mental health services, HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse. If you sign this release form, you give specific authorization for these records to be released. Personal and medical information will not be used for any purpose other than establishment of study medical eligibility and will not be released without your prior written consent for any reason.

This authorization is valid for ninety (90) days from the date signed. Authorizing the disclosure of this health information is voluntary: you do not need to sign this form. Whether you sign or not will have no effect on your child’s medical care. You can cancel this authorization at any time by writing to the Medical Records Department or your child’s doctor. Once the information has been released according to the terms of this authorization, the information cannot be recalled. If your child is not eligible to take part in the study, or if you choose not to take part in the study, all protected health information collected by the researchers will be destroyed or made anonymous.

Signature of patient/legal representative

Printed name

Relationship to patient

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Phone number

Date signed

Provider:
Please fax records related to abdominal pain within the past 2 years to Melissa Young at 206-987-2721.