AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I authorize: **Any and all providers**

To disclose to:

Akiko Shimamura, MD, PhD
Boston Children's Hospital
Karp Family Research Laboratory, 8210
Boston, MA 02115
Phone: 617-919-6109
Fax: 617-730-4679

Protected Health Information ("PHI") to be disclosed:

- ✓ Names and addresses of physicians following patient
- ✓ Hospital admission and discharge summaries
- ✓ Pulmonary function studies
- ✓ Growth charts
- ✓ Pathology reports
- ✓ Laboratory results
- ✓ Imaging study reports
- ✓ Consultation letters
- ✓ Medication records
- ✓ Clinic notes, Flow sheets
- ✓ Other (Specify):_____

Purpose: The purpose of this disclosure is to provide follow up information about diagnosis and treatment for severe chronic neutropenia conditions as part of the research program of Severe Chronic Neutropenia International Registry. This research program is focused primarily on collecting medical and non-medical information and opinions from people with severe chronic neutropenia conditions, to better learn how chronic neutropenia behaves and how it affects different people and families.

I understand that this authorization for disclosure of my PHI, unless expressly limited by me in writing, will extend to all aspects of diagnosis and treatment as listed above.

I understand that my PHI will be used for research purposes as described above. Redisclosure: I understand the researchers may need to disclose my PHI to institutional review boards and other entities and individuals as required by law. I understand that the researchers will comply with HIPAA as outlined in the consent form for this study. I also understand that confidentiality protections under federal and state law will apply to the research use of this information.

I understand that I do not have to sign this authorization. I understand that this authorization may be revoked in writing at any time by writing to the research team. If I do revoke my authorization, I understand that PHI that has already been released may still be used by the researchers. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Current Name: _____

LAST FIRST MIDDLE

Birth Date: _____

MONTH DATE YEAR

Full prior name(s) used, if applicable: _____

Signed: _____ **Date: _____**

(Patient, Parent, or Next-of-Kin)