MEDICAL RECORD RELEASE FORM

TO: Monogenic Diabetes Mellitus Registry (MDMR)
University of Chicago IRB Protocol Number: 15617B
Principal Investigator Directing Research: Siri Atma Greeley, MD, PhD
Address: Department of Medicine
5841 S. Maryland; N235; MC 1027
Chicago, IL 60637
Phone: (773) 702-0829

REGARDING:

PATIENT INFORMATION

Name (last, first, middle initial):		Date of Birth:
Address (Street, Apt. Number, City, State, and Zip Code):		
Phone Number:	**Social Security Number:**	**Medical Record Number:**

AUTHORIZATION:

I, ______________________________________ hereby authorize the organization listed below to disclose the individually identifiable health information about me listed below for the specific purpose of RESEARCH ON MONOGENIC DIABETES MELLITUS. Specifically, this information includes exact date of diagnosis, physician's assessment of the severity of illness, any unusual clinical features and suspicion for any possible genetic problem, diagnostic tests (insulin or c-peptide levels, autoantibodies or genetic tests) at onset or since, treatment at onset and subsequently (insulin, pills, diet alone), assessment of glucose control (HbA1c values), the presence or absence of specific signs and symptoms (for example, increased urination, increased thirst, appetite changes, weight loss, infection, diabetic ketoacidosis, the first blood glucose value), birthweight and length, and subsequent measures of growth and development, and any other conditions that may be relevant.

This use and disclosure may be made only by, and to, Dr. Siri Atma Greeley and the MDMR research staff.

This form authorizes the release of medical information regarding the patient listed above.

FROM:

Name of Organization:	
Street Address:	
City/State/Zip:	**Phone Number:**
Specific Facilities (if applicable):	

TO: Monogenic Diabetes Mellitus Registry - The University of Chicago
5841 S. Maryland Avenue; N235; MC 1027
Chicago, IL 60637
Phone: (773) 702-0829 Fax: (773) 926-0699

INFORMATION IS REQUESTED

For the following dates of treatment: ___________________________ to _________________________
For the following types of information:

________ HISTORY & PHYSICAL ________ DISCHARGE SUMMARY ________ EMERGENCY REPORTS

________CONSULTATION REPORTS ________ NURSES NOTES ________ FACE SHEET

________ LABORATORY REPORTS ________ PROGRESS/PHYSICIAN NOTES

This request does NOT include any of the following:

- **Diagnosis, evaluation and/or treatment for alcohol and/or drug abuse**
- **Records of HTLV-III or HIV testing (AIDS test) result, diagnosis and/or treatment**
- **Psychiatric, psychological records or evaluation and/or treatment for mental, physical and/or emotional illness**

This authorization will remain in effect for:

____ 90 Days ____ 1 Year ____ Until the following date: ____________________________

____ Other: ____

I may change my mind and revoke this Authorization in writing at any time by notifying the Organization Listed Above. Changing my mind will not affect my treatment. The revocation will not apply to the extent that the Organization has already taken action where it relied on my permission.

I have the right to inspect or copy any information used/disclosed under this authorization.

Once my health information is disclosed to the research project, there is no guarantee that the researchers will not redisclose the health information to a third party as required by law. The MDMR is required to comply with all privacy laws. Although it is unlikely, the MDMR may be required to disclose this health information to the agency funding this research, the National Institutes of Health (NIH). If so, the same laws that the University of Chicago must obey may not protect your health information. Your information may also be reviewed by the federal agency whose responsibility it is to protect human subjects in research: the Office of Human Research Protection (OHRP). Representatives of the University of Chicago, including the Institutional Review Board, a committee that oversees research, may also view the data from this study.

I may refuse to sign this authorization, and if I do refuse, my ability to obtain treatment will not be affected.

I have read this authorization and have had a chance to ask questions about the disclosure of health information. I authorize the Organization Listed Above to use/disclose my health information as described above.

____ _______________________________
*Signature of Patient or Personal Representative** *Date*

____ _______________________________
*Name of Personal Representative** *(if applicable)* *Relationship to Patient*

____ _______________________________
Witness (if applicable) *Date*

*****_The Personal Representative is the patient's decision maker. It can be the parent if the patient is a minor, legal guardian, health care surrogate, or other person._