

Track changes noted in red: added 'participant' before 'dob'

AUTHORIZATION TO RELEASE MEDICAL RECORDS (Protected Health Information)

Please complete the survey below.

Thank you!

The Women's Health Initiative (WHI) Extension Study is a national study sponsored by the National Institutes of Health (NIH) whose ongoing purpose is to learn about the health of post-menopausal women. By signing this form I give permission to these facilities to give information about my health care and health conditions to: The investigators at the WHI Clinical Coordinating Center (CCC) and the Regional Center affiliates.

The information released will only be used for research purposes by the WHI and will be held in strict confidence. Examples of medical information to be requested:

- Discharge summary
- History and physical
- Radiology/imaging
- Pathology reports/specimens
- ER records
- Operative reports
- Procedure reports
- Lab tests and results
- Diagnostic/procedure codes
- Consultations
- Outpatient/short stay records
- MD notes/progress notes
- Other: _____

By signing, I acknowledge that I have read and understood the following:


- Signing this authorization is voluntary.
- Although not being asked by WHI, information released may include all aspects of treatment, including testing and/or treatment of sexually transmitted diseases, AIDS or HIV infection, alcohol and/or drug abuse, and mental health conditions.
- I have the right to revoke (cancel) this authorization at any time by notifying WHI and the facility in writing. If I do this, it will be in effect immediately as soon as it is received and no further information about my health care and health conditions will be requested. If I revoke this authorization, it will not affect information already released and will not affect my enrollment or participation in WHI or my treatment, payment, enrollment, or eligibility for benefits at this facility.
- The above medical records may be shared with researchers at the WHI CCC at Fred Hutchinson Cancer Research Center, WHI Regional Centers and their affiliates, the NIH (study sponsor), and regulatory agencies and review boards who watch over the safety, effectiveness and conduct of the research. Any disclosure of information carries with it the potential for an unauthorized re-disclosure and may not be protected by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule but WHI, as a nationally funded research study, has established continued protection for the disclosed information.
- WHI **cannot** further use or disclose the information in my medical records without my consent unless required by law.
- This authorization shall remain valid for the duration of the WHI Extension Study.
- I have the right to receive a copy of this authorization.
- A photocopy or facsimile of this document is as valid as the original.

I give permission for any and all facilities and providers to release my health information.

Form 330 Screenshots

Signature of WHI Participant
(or Authorized Representative)


* must provide value

 [Add signature](#)

Click on "Add Signature" and use your mouse or finger to draw your signature. Typing will not work.

Today's Date:

* must provide value

06-16-2020  M-D-Y
MM/DD/YYYY

First Name of WHI Participant
(or Authorized Representative)

* must provide value

Last Name of WHI Participant
(or Authorized Representative)

* must provide value

Relationship to participant

* must provide value

- Self
 Other, on behalf of WHI participant

[reset](#)

Participant's Date of Birth:

* must provide value

 M-D-Y
MM/DD/YYYY

Phone number:

* must provide value

A signed copy of this form is provided on the next page. You may download or print this page for your records. You will be asked to certify the information you provided above before a copy is submitted to the WHI offices.

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Displayed below is a read-only copy of your survey responses. Please review it and the options at the bottom.

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I certify that all the information in the document above is correct. I understand that clicking 'Submit' will electronically sign the form and that signing this form electronically is the equivalent of signing a physical document.

If any information above is not correct, you may click the 'Previous Page' button to go back and correct it.

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Submit

Save & Return Later

Form 330 Screenshots

Close survey

Thank you for submitting your form. If you are unsure about or wish to change an answer, please contact the WHI Clinical Coordinating Center at {1-800-218-8415} or email us at participant@whi.org

Has your phone number changed in the last year?

If it has, please contact your Regional Center, Stanford University at (888) 729-8442.