FIGURE B.1

Model General Medical Release Form

Office use only.	**- Affix label here-** Clinical Center/ID: __ __ __ __ - ___ ___ ___ - __ First Name _____M.I._____ Last Name _____

1. **Explanation:**

   This consent is for release of medical and health care information from your doctor, clinic, or other health care provider.

2. **Consent:**

   I hereby give my consent for: _____ (Name of Doctor, Clinic, or Health Care Provider)

   _____ Address

   _____ City State Zip

   to provide copies of my medical records to: _____ CC Name

   _____ Address

   _____ City State Zip

   Phone: _____

   Medical records to include: _____

   _____

   _____

3. Approximate date of last medical treatment, condition, or service: __ __/__ __/__ __

4. **Purpose:** The medical information that is released will only be used for research purposes by the Women's Health Initiative (WHI) research staff.

5. **Duration:** This consent is effective upon signing and shall remain valid for the duration of the WHI study (1993-2008).

6. **Restrictions:** I understand this information will be used only for research purposes and will not be released by the WHI staff without my consent.

7. Signed: _____ _____
   (Study Participant/Spouse/Responsible Party) (Date)

   If signed by other than participant, indicate relationship: _____

   *Printed name of study participant:*_____

   Witness: _____
   Signature

   Spanish Translator: ☐ Yes _____ ☐ No
   Signature

FIGURE B.2

Model Request for Medical Information

[Date]

[Medical Institution]
[Address]
[City, State Zip]

RE: [Participant's Name]
[DOB]
[SS#]
[Dates of medical care]

Dear _____:

The [Name of your institution] is involved in the Women's Health Initiative (WHI), a study of ways to prevent breast cancer, colon and rectal cancer, heart disease, and fractures in women ages 50 to 79. About 160,000 women from 40 centers in the United States will take part in this study which is funded by the National Institutes of Health. The Principal Investigator for this study at our institution is [PIs' Name].

As part of our study we are tracking all participants who develop certain events, such as cancer, heart disease, fracture, any hospitalization or death. We understand the above participant may have been treated for _____ on or about [Date of diagnosis on *Form 33D - Medical History Update (Detail)*]. We would appreciate any medical records related to this event for confirmation of the diagnosis. Attached is a release of medical records form signed by the participant indicating the documents needed.

Please forward this information to:

[Your address]

[Attention whoever]

Thank you for your prompt attention to this matter. If you have any questions or concerns please feel free to call [Outcomes Specialist or PI] at [phone number] for further information.

Sincerely,

PI or Designee
Title

Appendix B
Letters and Forms

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