AUTHORIZATION TO RELEASE MEDICAL RECORDS
(Protected Health Information)

OFFICE USE ONLY
Release records from:

Release records to:
Women's Health Initiative

NE Regional Center Sites

☐ University at Buffalo
65 Farber Hall
Buffalo, NY 14214
716-829-3128; 855-944-2255

☐ Brigham & Women's Hospital
Division of Preventive Medicine
900 Commonwealth Ave E, 3rd Fl.
Boston, MA 02215
617-278-0791; 800-510-4858

SE Regional Center Site

☐ Wake Forest School of Medicine
Medical Center Blvd.
Campus Box 3151
Winston Salem, NC 27157
877-736-4962
336-713-8646 (Fax)

Midwest Regional Center Sites

☐ OSU at Wexner Medical Center
1581 Dodd Dr., Suite 140
Columbus, OH 43210
614-688-3563; 800-251-1175

West Regional Center Sites

☐ Stanford WHI Regional Center
1070 Arastradero Rd., Suite 100
Palo Alto, CA 94304
888-729-8442

Clinical Coordinating Center

☐ Fred Hutch (WHI)
1100 Fairview Ave N, M3-A410
Seattle, WA 98109
800-514-0325

Participant ID Label

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
- Other: _____
- Consultations
- Outpatient/ short stay records
- MD notes/ progress notes

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.

Continued on next page. ⟶

- 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.

_____ Today's Date: ___ ___-___ ___- 20 ___ ___
Signature of WHI Participant (or Authorized Representative) Month Day Year

_____ Participant's Date of Birth: ___ ___-___ ___- 19 ___ ___
Printed Name of WHI Participant (or Authorized Representative and relationship to participant) Month Day Year

Phone number: (_____) _____ - _____

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