Akron Children's Hospital

AUTHORIZATION for RELEASE of MEDICAL INFORMATION for RESEARCH

Protocol Title/Number

A Patient Name (Please Print) Last: Stumpf First: Ella Middle: M

Date of Birth 12/08/2011 Phone 419 681 4305 MR# 1469899

Address 70 Kimberwick Road (Street) Lexington (City) OH (State) 44904 (Zip)

B **The undersigned authorizes the use or disclosure of the above named individual's health information by Akron Children's Hospital or its subsidiaries (Children's) as described below:**

C 1. ***Use/Disclose information to the Person(s) and/or Organization(s) listed below and on the attached Information Sheet*:***

Name Dr Jena Naffaa Phone/Fax 330 543 8275 / 3760

Address One Perkins Square (Street) Akron (City) OH (State) 44308 (Zip)

See attached Information Sheet for a complete listing of the entities with whom information will be shared.

D 2. ***Purpose of Use of Disclosure:***

☐ At request of patient ☑ Research Database or Repository ☐ Billing/Payment ☐ Other

3. ***Treatment during clinical trial is CONDITIONED UPON THE SIGNING OF THIS AUTHORIZATION::*** **Check One:** ☐ Yes ☑ No

E 4. ***Type of information to be used or disclosed:***

☑ Complete Medical Record ☐ Consultation Reports ☐ Pathology Reports
☐ History & Physical ☑ Diagnostic Imaging Reports ☐ Photographs/videotapes
☐ Progress Notes ☐ Lab Reports ☐ Diagnosis & Treatment Codes
☐ Discharge Summary ☑ Radiology Reports/Films ☐ Other

5. ***Treatment date(s)*** Not applicable

F Unless revoked, this authorization will expire at the end of the research study or on the following date or event: no expiration date

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that if the person(s) or class(es) of persons in Sections B 1 are not health care providers, health plans or health care clearing houses covered by the Federal privacy regulations, the protected health information they receive may be further used or disclosed by them and may not be protected any longer by the Federal privacy regulations.

I understand that this Authorization may be revoked at any time, except to the extent that Children's has taken action in reliance on this Authorization. Notify in writing, the Privacy Officer, Akron Children's Hospital, One Perkins Square, Akron, OH 44308. I understand that Children's can use and disclose health information obtained prior to the effective date of such revocation to maintain the integrity of the research data.

I understand that access to my health information may be restricted for the duration of the research study. However, once the study has concluded at all sites, I can inspect and obtain a copy of this information.

Signature of Patient or Parent/Legal Guardian — Date: 2-17-14

If this Authorization is signed by the Parent/Legal Guardian, please specify the relationship to the patient/authority to sign on behalf of the individual

Signature of Witness — Date