

Bastyr Integrated Oncology Research Center

Medical Records Release

Name: _____

LAST FIRST M.I.

We are asking for your permission to access your medical records relating to your cancer diagnosis, and any treatments for cancer or related problems. Please read the following information about your rights as a research participant regarding your protected health information and how that information will be used during the period outlined below.

What are my rights as far as my medical records and this study are concerned?

You have rights regarding the privacy of medical information that is collected before, during, and after your participation in this study. This medical information, called “protected health information” (PHI), includes demographic information and the results of some or all of the following tests: physical exams, analysis of blood or tissue specimens, x-rays and other diagnostic and medical procedures, as well as your medical history. You have the right to limit the use and sharing of your PHI.

What does my signature on this Release Form mean?

By signing this release form, you are allowing the research team to have access to your PHI, as well as relevant medical record information obtained from any physicians that provide medical care or treatment relating to your cancer diagnosis and treatment. You do not have to give permission for disclosure of your PHI. However, if you decide not to give permission, you will not be able to participate in this research study.

How will this study protect my privacy?

Information gained from your medical chart will only be identifiable by a special study identification number, and your name will not appear in any reports or publications about this research. The research team that will have access to your PHI collected for this study includes the investigators listed on the Consent form you completed for this study form and personnel at participating institutions, including Fred Hutchinson Cancer Research Center. Your PHI will be used only for the research purposes described in the consent form and will not be sold or distributed. If necessary, the PHI we have collected will be shared with the Institutional Review Board (IRB) and with any person or agency that is required by law. Your name and personal contact information will remain in a confidential database and will not appear on any specimens or family and medical history data shared with the research organization.

How long will this information be stored?

By signing this form, you are authorizing us to store the PHI specified in this form in a confidential database and for a maximum of five years after completion of this study (no later than 2013). You may revoke this authorization at any time by contacting the principal investigator (Dr. Standish) in writing at the address listed below. If you revoke this authorization, no additional PHI will be collected; however, the PHI already stored in the database and repository may still be used. Once your PHI has been shared with study researchers and staff, the Privacy Rule in a federal law called the Health Insurance Portability and Accountability Act (“HIPAA”) may no longer apply. The Privacy Rule protects the rights of individuals by governing the release of PHI from health care institutions to researchers, but does not govern the use of your PHI once it has been released. However, other confidentiality protections under federal and state law are in place to protect your rights during your participation in research studies.

Name: _____
LAST FIRST M.I.

I hereby authorize the disclosure of all medical records relating to my cancer diagnosis, and any treatments for cancer to:

Investigators and staff of the BIORC Outcomes Study
 Dr. Leanna Standish ND, PhD, LAc Bastyr University Research Institute, 14500 Juanita Dr NE Kenmore WA
 98028
 M. Robyn Andersen PhD. MPH Fred Hutchinson Cancer Research Center
 Dr. Erin Sweet ND Bastyr University Research Institute

I understand that this medical records release authorizes research personnel to periodically review my medical records for up to 5 years (or until 2013) in order to obtain information relating to my gynecologic health, any treatments for cancer, and my risk for cancer, including results of genetic testing that relate specifically to my cancer diagnosis. Relevant medical record information, such as prior history of cancer and treatment, may be obtained from any physicians that provide medical care or treatment relating to my cancer. I understand that information obtained from my medical chart will only be identifiable by a special study number and that my name will not appear on any reports of the results of these studies.

I understand that this authorization may be revoked in writing at any time. I understand that I am entitled to receive a copy of this authorization to keep for my records.

Signed: _____ Date: ____/____/____
(PATIENT)
 _____ Date: ____/____/____
(OR LEGALLY AUTHORIZED REPRESENTATIVE AND RELATIONSHIP)

To Mail the Medical Records:
 Bastyr Center for Natural Health
 3670 Stone Way N.
 Seattle, WA 98103

To Fax the Medical Records:
 (425) 602-3420