Authorization for Disclosure of Protected Health Information to the International DIPG/DMG Registry

I, _____, authorize_____
(Print your name) *(Print name of hospital(s))*

to disclose my child's:

Child's Name: _____ Date of Birth: _____ Date of Death: _____

Health information and medical records consisting of the following:

- Demographic information
- Radiology images and reports
- Pathology reports
- Operative reports
- History & physical exam reports
- Treatment documentation
- Consultation reports
- Other records pertinent and relevant to DIPG/DMG diagnosis

To the following person:

Name: _____
(name of person requesting information)

At
The International DIPG/DMG Registry
Cincinnati Children's Hospital Medical Center
240 Albert Sabin Way
Cincinnati, Ohio 45229

Telephone: 1-877-349-8074
Email: referrals@dipgregistry.org

This Authorization will remain in effect for the duration of your participation in the DIPG/DMG registry. This Authorization may be revoked at any time to the extent that use and/or disclosure has not already occurred prior to your request for revocation. In order to revoke the authorization, the individual/parent/legal guardian must submit a revocation request in writing to the entity disclosing protected health information to Cincinnati Children's Hospital Medical Center listed above.

I understand the purpose for disclosing this protected health information to the person noted above for purposes of the International DIPG/DMG Registry.

Printed Name: _____ Phone: _____

Address: _____

_____

Signature: _____ Date: _____