



APR 26 2011



For the Use and/or Release of Protected Health Information for Research

Research Title: International Registry of Werner Syndrome/Cell Bank  
Lead researcher: George M. Martin, MD  
Institution of lead researcher: University of Washington

**A. Purpose of this form**

The purpose of this form is to give your permission to the research team to obtain and use your protected health information. Your health information will be used to do the research named above.

*This document is also used for parents to provide permission about the protected health information of their minor children, and for legally-authorized representatives of (such as an appropriate family member) to provide permission about the protected health information of individuals who are not capable themselves of providing permission. In such cases, the terms "you" and "your health information" refer to the subject rather than the person providing permission.*

State and federal privacy laws protect your health information. These laws say that, in most cases, your health care provider can release your identifiable health information to the research team only if you give permission by signing this form.

You do not have to sign this permission form. If you do not, you will not be allowed to join the research study. Your decision to not sign this permission will not affect any other treatment, health care, enrollment in health plans or eligibility for benefits.

**B. The protected health information that will be obtained and used**

"Protected health information" means the health information in your medical or other healthcare records. It also includes information in your records that can identify you. For example, it can include your name, address, phone number, birthdate, and medical record number.

By signing this form you are giving permission to the following organization(s) to disclose your protected health information for this research.

Name of health care organization(s):

This permission is for the health care provided to you during the following time period: From the onset of premature aging symptoms until the end of this research study.

The specific information that will be released and used for this research is listed below:

- Medical history / treatment
- Consultation
- Radiology films (like X-rays or CT scans)







- \_\_\_\_\_ AIDS or HIV
- \_\_\_\_\_ Behavioral or mental health services, including psychotherapy notes
- \_\_\_\_\_ Drug or alcohol abuse, diagnosis, or treatment

---

Printed Name of Research Subject

Birthdate

---

Signature of Research Subject

Date of signature

---

Printed Name of Subject's Representative

---

Signature of Subject's Representative

Date of signature

---

Description of Representative's authority to act for subject (for example: parent)

