UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

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REQUEST TO RELEASE_____MEDICAL RECORDS
(name of patient)

Dr. Elliott Sherr and his colleagues at the Brain Development Research Program (BDRP) at the University of California, San Francisco (UCSF), are conducting genetic research on brain malformations. The research team will need to review each prospective participant's medical records. The signature below gives the authorization to send the following patient's:_____ (DOB: _____) medical records and MRI scans directly to the study. Please find below the address to mail the copies.

My signature below authorizes _____
HOSPITAL/MRI FACILITY/DOCTOR NAME

to release the following information to the Brain Development Research Program at the University of California, San Francisco.

Information to be released:

☐ Complete Medical Record ☐ Radiology Films ☐ Genetic Testing Information

☐ Ophthalmology Reports ☐ Laboratory Reports ☐ Other:_____

This authorization is completely **voluntary**. This authorization is valid **until**: *(please select from the options listed below).*

____I choose to revoke it ***or***

____the specified date. Please void this release form after this date: _____

I can choose to revoke (end) this authorization at any time by notifying the Brain Development Research Program in writing or by phone.

_____ _____
PRINT PATIENT/PARENT NAME PATIENT/PARENT SIGNATURE

_____ _____
PRINT PATIENT NAME DATE SIGNED

Please send all the requested records to the following address. Packages can be signed for at this location.

Brain Development Research Program
University of California, San Francisco
675 Nelson Rising Lane, Box 3206
San Francisco, CA 94158
Office: 415-502-8039
Fax: 415-476-2723

If you have any questions, please contact the Research Coordinator at:

Phone: 415-502-8039
Fax: 415-476-2723