DIPG REGISTRY
Working together to find a cure
for diffuse intrinsic pontine glioma

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

I, _____, authorize_____
(Print your name) *(Print name of health information custodian)*

to disclose (check one)
my own
my child's
Child's name:_____ Date of Birth:_____

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 diagnosis

To the following person:

Name:_____
(name of person requesting information)

At The International DIPG Registry
Cincinnati Children's Hospital Medical Center
3333 Burnet Avenue
MLC 11027
Cincinnati, OH 45229

This Authorization will remain in effect for the duration of your participation in the DIPG 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 Registry.

Printed Name:_____ Phone:_____

Address:_____

_____

Signature:_____ Date:_____