REQUEST FOR RELEASE OF MEDICAL INFORMATION

I HEREBY REQUEST THAT MEDICAL INFORMATION AND/OR MEDICAL RECORDS RELATED TO MY PREGNANCY BE RELEASED TO:

Ribavirin Pregnancy Registry Study Coordinating Center
Research Park
1011 Ashes Drive
Wilmington, NC 28405
Phone number: 800-593-2214
Fax number: 800-800-1052

RECORDS TO BE RELEASED FROM:

Name of Health Care Provider: ______________________________

Specialty: ______________________________

Address: ______________________________

____

Telephone number: ______________________________

Fax number (if available): ______________________________

Comments: ______________________________

____

☐ Verbal consent given by patient to CRA over phone on: ____________
Date

____
Signature of Clinical Research Associate Date

____
Printed name of Patient

____
Signature of Patient Date

____
Address of Patient

____

____
Telephone number of Patient

Patient ID: __________

REQUEST FOR RELEASE OF MEDICAL INFORMATION

I HEREBY REQUEST THAT MEDICAL INFORMATION AND/OR MEDICAL RECORDS FOR MY BABY BE RELEASED TO:

Ribavirin Pregnancy Registry Study Coordinating Center
Research Park
1011 Ashes Drive
Wilmington, NC 28405
Phone number: 800-593-2214
Fax number: 800-800-1052

RECORDS TO BE RELEASED FROM:

Name of Health Care Provider: ______________________________

Specialty: ______________________________

Address: ______________________________

____

Telephone number: ______________________________

Fax number (if available): ______________________________

Comments: ______________________________

____

☐ Verbal consent given by patient to CRA over phone on: ______________
Date

____
Signature of Clinical Research Associate   Date

____
Printed name of Baby

____
Printed name of Baby's Mother

____
Signature of Baby's Mother   Date

____
Address of Baby's Mother

____

____
Telephone number of Baby's Mother

Patient ID: __________

REQUEST FOR RELEASE OF MEDICAL INFORMATION

I HEREBY REQUEST THAT MEDICAL INFORMATION AND/OR MEDICAL RECORDS RELATED TO MY TAKING RIBAVIRIN BE RELEASED TO:

Ribavirin Pregnancy Registry Study Coordinating Center
Research Park
1011 Ashes Drive
Wilmington, NC 28405
Phone number: 800-593-2214
Fax number: 800-800-1052

RECORDS TO BE RELEASED FROM:

Name of Health Care Provider: ______________________________

Specialty: ______________________________

Address: ______________________________

____

Telephone number: ______________________________

Fax number (if available): ______________________________

Comments: ______________________________

____

☐ Verbal consent given by patient to CRA over phone on: ______________
Date

____
Signature of Clinical Research Associate   Date

____
Printed name of Patient

____
Signature of Patient   Date

____
Address of Patient

____

____
Telephone number of Patient

Patient ID: __________