

**North American Wilms Tumor Study, NAWTS
Consent for Disclosure of Medical Record Information (Child)**

Consent for disclosure of medical information of your child is optional, but it would allow the researchers to look into the medical history in depth, which will help to uncover the cause of Wilms tumor.

Patient's Name _____ Date of Birth _____
Last Name First Name Initial (YYYY - MM - DD)
 Address _____ Telephone # (____) _____
Street City State/Province

I authorize my health care providers (listed below) to disclose my health information to:

Dr. Rayjean J. Hung,
 Samuel Lunenfeld Research Institute, Mount Sinai Hospital, 60 Murray St., Toronto, ON M5T 3L9
 Telephone # (416) 586-4750, Fax # (416) 586-8404

Health Care Providers:

1. Doctor/Health Care Provider's Name _____
 Address _____
Street City State/Province Zip/Postal Code
 Telephone # (____) _____ Fax # (____) _____

2. Doctor/Health Care Provider's Name _____
 Address _____
Street City State/Province Zip/Postal Code
 Telephone # (____) _____ Fax # (____) _____

3. Doctor/Health Care Provider's Name _____
 Address _____
Street City State/Province Zip/Postal Code
 Telephone # (____) _____ Fax # (____) _____

The reason for this request is to provide information to researchers with the North American Wilms Tumor Study, an investigation into the environmental factors, medical conditions, genetic susceptibility and their effects on the risk of childhood cancer.

The health information that may be accessed for this research are as follows:

- All records, including the results of lab and genetic tests;
- Personal health information relating to (specify health information): _____

Only records relating to the following treatment(s) or admission(s):

1. Type of Treatment _____ Date of Treatment/Admission: _____
(YYYY - MM - DD)
2. Type of Treatment _____ Date of Treatment/Admission: _____
(YYYY - MM - DD)
3. Type of Treatment _____ Date of Treatment/Admission: _____
(YYYY - MM - DD)

This authorization expires five years from the date signed or as stated: _____

Health care providers are required by law to protect your health information. Medical information accessed will only be used for the purposes of this research and will not be used for any other research study in the future.

- I understand the purpose for disclosing this personal health information to the person noted above.
- I understand that I can refuse to sign this Consent Form and may revoke this authorization at any time.

Signature of Patient or legal guardian

Signature of Witness

Date (YYYY/MM/DD)

If the patient/legal guardian does not read or understand English, the consent form must be interpreted for the patient. The person who acts as the interpreter must sign this form as a witness to confirm that this has been done.

Signature of Interpreter

Name of Interpreter/Relationship to Subject if Any

Date (YYYY/MM/DD)

Note: Copy and provide a copy of this form to the patient.

**HIPAA¹ AUTHORIZATION TO USE AND DISCLOSE
INDIVIDUAL HEALTH INFORMATION FOR RESEARCH PURPOSES**

NORTH AMERICAN WILMS TUMOR STUDY

1. Purpose. As the research participant's personal representative, I authorize Rayjean J. Hung and the researcher's staff to use and disclose my child's individual health information for the purpose of conducting the research project entitled NORTH AMERICAN WILMS TUMOR STUDY (NAWTS).

2. Individual Health Information to be Used or Disclosed. My child's individual health information that may be used or disclosed to conduct this research includes those as listed on the North American Wilms Tumor Study, Consent for Disclosure of Medical Record Information.

3. Parties Who May Disclose My Individual Health Information. The researcher and the researcher's staff may obtain my child's individual health information from health care providers as listed on the North American Wilms Tumor Study, Consent for Disclosure of Medical Record Information.

4. Parties Who May Receive or Use My Individual Health Information. The individual health information disclosed by parties listed in item 3 and information disclosed by my child during the course of the research may be received and used by Rayjean J. Hung and the researcher's staff. Also, if my child receives compensation for participating in this study, identifying information about my child may be used or disclosed as necessary to provide compensation.

5. Right to Refuse to Sign this Authorization. I do not have to sign this Authorization. My decision not to sign this authorization will not affect my child's eligibility for other treatment, payment, or enrollment in health plans or eligibility for benefits.

6. Right to Revoke. I can change my mind and withdraw this authorization at any time by sending a written notice to Rayjean J. Hung, 60 Murray Street, Box 18, Room L5-215, Toronto, ON, M5T 3L9, Canada to inform the researcher of my decision. If I withdraw this authorization, the researcher may only use and disclose the protected health information already collected for this research study. No further health information about my child will be collected by or disclosed to the researcher for this study.

7. Potential for Re-disclosure. My child's individual health information disclosed under this authorization may be subject to re-disclosure outside the research study and no longer protected. For example, researchers in other studies could use my child's individual health information collected for this study without contacting me if they get approval from an Institutional Review Board (IRB) and agree to keep my child's information confidential.

7A. Also, there are other laws that may require my child's individual health information to be disclosed for public purposes. Examples include potential disclosures if required for mandated reporting of abuse or neglect, judicial proceedings, health oversight activities and public health measures.

This authorization expires five years from the date signed.

I am the personal representative authorized to act on behalf of the participant.

I have read this information, and I will receive a copy of this authorization form after it is signed.

signature of research participant's
personal representative

date

¹ HIPAA is the Health Insurance Portability and Accountability Act of 1996, a federal law related to privacy of health information.

printed name of research participant's
personal representative

description of personal representative's authority to act on behalf
of the research participant

printed name of research participant