SUDCRRC
SUDC Registry and Research Collaborative

Authorization for the Release of Medical Information

NO PHYSICIAN OR INSTITUTION MAY GIVE CONFIDENTIAL INFORMATION WITHOUT THE CONSENT OF THE PATIENT. IF THE PATIENT IS A MINOR, THE CONSENT FORM MUST BE SIGNED BY THE PARENT OR LEGAL GUARDIAN AND SHOULD BE WITNESSED.I have enrolled my child in a research trial studying Sudden Unexplained Death in Children (SUDC). It has been approved by the IRB of NYU Langone Medical Center. For More Information: http://sudc.org/Research/SUDCRRC.aspx I would like for your office to release the below information. Thank you very much for your cooperation.

Kindly furnish to:
SUDCRRC Attn: Laura Gould
NYU Comprehensive Epilepsy Center
223 East 34th Street
Ground Floor
New York, NY 10016
Fax: 646-754-9892
Email: laura.gould@nyulangone.org

Ship via:

Priority Mail with Tracking ID. If you require shipping supplies, shipping slip or reimbursement for costs of making copies of histologic glass slides, please contact Laura Crandall (laura.gould@nyulangone.org or via 646-754-2230)

Please release to the SUDCRRC the following checked items from my child's medical records:

- ☐ Autopsy Report
- ☐ Death Scene Investigation Report
- ☐ Copies of Histology Slides (H&E stained)
- ☐ Death Certificate/Cause of Death Statement if not included in autopsy report
- ☐ Consultation Reports (Neuropathology, Cardiac pathology, as applicable)
- ☐ Toxicology, Microbiology, Virology Reports if testing was performed
- ☐ Ancillary reports, as applicable
- ☐ Information of Specimens stored for potential further testing (ex: genetic analysis)
- ☐ Biospecimens (including blood, vitreous fluids, tissue/organ or blood spot cards for additional investigation)
- ☐ Investigative photographs (Death Scene and Autopsy)
- ☒ Clinical Records including Prenatal and Birth Records (Service Dates_____to_____)
- ☒ Electrophysiology data (EKG, EEG, video EEG monitoring), Service Dates____to____)
- ☒ Vaccination Records from_____to _____
- ☒ X-rays, Imaging Study Reports and Digitized Study Images (Relevant Service Dates _____)

The name of the patient: (First, Middle, Last) _____

Patient's former surname (if applicable): _____

Their DOB of the patient:_____ Their DOD (if deceased): _____

My Relation to above patient (circle one): PARENT GUARDIAN SELF

PRINTED NAME of PATIENT, PARENT OR GUARDIAN: _____

SIGNATURE: _____

DATE:_____WITNESS: _____