

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 releast 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)

Former surname for the patient (if applicable):

Their DOB: _____

Their DOD (if deceased): _____

My Relation to above child (circle one):

PARENT GUARDIAN SELF

PRINTED NAME of PATIENT, PARENT OR GUARDIAN:

SIGNATURE:

DATE: _____

Subscribed and sworn to me, on
Date: _____
Signed: _____
Name: _____

(notary stamp above)