I, **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, birthdate\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_,** have signed a consent

**Patient’s first & last name, printed Patient’s date of birth**

form to participate in CHANGE AFib clinical trial,a clinical research study. For the purposes of the study, I give permission to the study team, including personnel at the American Heart Association (AHA), to collect medical information and billing information from any medical or healthcare facility I visit or at which I’m seen during my participation in the study.

The information I agree to have disclosed for the research includes:

* Medical bills (UB04 and/or Abstract Coding Summary)
* Hospital discharge summaries
* Reports from procedures, surgeries, laboratory tests, biopsies, radiologic images
* Results of autopsy
* Hospital patient discharge instructions
* Clinic notes/visits

This list represents the most information the study team could collect, but the team will ask for the minimum necessary for research purposes and limited to specified dates of service.

By signing this form, I authorize the patient accounts and medical records departments at any medical or healthcare facility at which I am treated or evaluated to disclose medical information and billing information to the CHANGE AFib clinical Study team.

I understand that I am allowed to revoke this authorization, in writing, at any time, however information that has been released based on my authorization can still be used for research purposes. Unless revoked earlier, this authorization will expire at the end of the clinical trial study. I understand that information used or disclosed by means of this authorization could be re-disclosed and would no longer be protected under federal law. I will receive a copy of this authorization.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Date Signed \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_**

**(Patient’S Signature)**

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

**Study Personnel will complete this section:**

For this research subject, please supply the information indicated by a checked box below or, as indicated on the fax cover sheet:

* Medical bills (UB04 and/or Abstract Coding Summary)
* Hospital discharge summaries
* Reports from procedures, surgeries, laboratory tests, biopsies, radiologic images
* Results of autopsy
* Hospital patient discharge instructions
* Clinic notes/visits

**For date(s) of service** [Or, as indicated on the fax cover sheet] **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please mail or fax the information requested to the selected location:**

|  |  |  |  |
| --- | --- | --- | --- |
| * **Site** | | * **AHA** | |
| **By Mail:** [Site Name]  ATTN: [Study Coordinator Name]  [Insert Site street address]  [Insert site city, state, zip][insert site mailing address | **By Fax:**  [XXX-XXX-XXXX] | **By Mail:** AHA  TTN:CHANGE AF Team  Address | **By Fax:**  XXX-XXX-XXXX |