Authorization for Release of Medical Information to the: Multiple Autoimmune Disease Genetics Consortium (MADGC) Research Study

The Feinstein Institute for Medical Research

I have been informed about the Genetics of Families with Multiple Autoimmune Diseases Research Study at The Feinstein Institute for Medical Research and agree to be contacted by a research coordinator, in order to learn more about the study. **I am under no obligation to participate**. My decision will not affect the care I receive.

_____ _____
Patient's Signature Date

Patient - please complete:

Name: _____

Date of Birth: _____

Address: _____

_____

Phone: _____

MD Office - please complete:

Referring Physician: _____

Office Contact: _____

Phone: _____

Diagnosis: _____

Date/Time of Next Appointment: _____

_____

PLEASE FAX TO:►	**MADGC 2 Research Study** **PETER K. GREGERSEN, MD** **FAX #: (516) 562-1153** **PHONE #: (877) 698- 9467**

THE SIGNED ORIGINAL MUST BE FILED IN THE PATIENT'S MEDICAL RECORD.