INDIANA UNIVERSITY HOSPITALS

AUTHORIZATION TO RELEASE INFORMATION

I hereby request and authorize any physician, hospital, school, and/or agency or their representative to release any or all information in their files concerning:

_____

to the SMA Research Roster in the Department of Medical and Molecular Genetics, Indiana University School of Medicine.

Hospital Number_____ Date of Birth_____

Social Security #_____

Date_____ Signed_____

_____
Relationship, if other than patient

Address_____

_____

Witness_____

Address_____

_____

Date_____

Witness_____

Address_____

_____

Date_____

USE ONE SIDE ONLY