JAIN FOUNDATION ORCHESTRATING A CURE
LGMD2B DYSFERLINOPATHY MIYOSHI
9725 Third Avenue NE, Suite 204 |Seattle, Washington 98115 | USA | Phone: 425-882-1492| Fax: 425-658-1703 | www.jain-foundation.org

Jain Foundation Communication Consent Form

In the event that we need to communicate with your medical provider(s) to discuss information pertaining to your muscular dystrophy, we request that you give both the Jain Foundation and your medical provider(s) permission by completing and signing this Communication Consent Form. Thank you.

I undersigned

Last Name: _____

First Name: _____

Date of Birth: _____

authorize the Jain Foundation Inc., Seattle, Washington, USA, and the medical provider(s) listed below to discuss my medical information pertinent to my muscular dystrophy:

1. **Name of Medical Provider: _____**

   Phone Number of Provider: _____

2. Name of Medical Provider: _____

   Phone Number of Provider: _____

3. Name of Medical Provider: _____

   Phone Number of Provider: _____

Signature: _____

Date: _____

A copy of this authorization is as valid as the original.

Original – Return to the Jain Foundation at the address or by the fax number indicated above

Copies – Retain for your files

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Authorization for Release of Medical Information for Jain Foundation Patient Registry

(If we need to obtain your medical information from multiple providers, please make copies of the blank form, and complete the form for each medical provider with their respective contact information)

Patient Name: _____ Date of Birth: _____

Former/maiden name(s) that records may be filed under: _____

Address: _____ City/State/Zip Code: _____

Patient's Phone Number: _____ Date of Request: _____

We are requesting records from your neurologist, physician, MDA clinic, or diagnostic/research lab about your muscle disease only.

I authorize the Jain Foundation Inc. to obtain information from:

Provider name: _____

Address: _____

Phone: _____

Fax: _____

Records Requested and Date(s) of Service: _____ (DOB) to _____ (Today's date)

- **Pathology and diagnostics reports, clinic/doctor's notes, and all records pertaining to patient's muscular dystrophy**

Purpose for This Request: To obtain medical information for the Jain Foundation patient registry.
Duration: Authorization is valid for one year from the date of signature or until _____ (date).

SEND RECORDS TO: Jain Foundation Inc.
9725 Third Ave. NE, Suite 204
Seattle, WA 98115

Phone: (425) 882-1492
Fax: (425) 658-1703
Web: www.jain-foundation.org

I understand that:

- My right to health care treatment is not conditioned on this authorization.
- The recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- I may cancel this authorization at any time by submitting a written request to the address provided in the "SEND RECORDS TO" section of this form, except where a disclosure has already been made in reliance on my prior authorization.

Signature of Patient or Representative: _____ Date: _____

Relationship to Patient (if requester is not the patient): _____

A copy of this authorization is as valid as the original. Patient or requester has a right to a copy of this authorization.

Please return the completed form to the Jain Foundation as indicated above. (JFRM-20131)