THE UNIVERSITY OF BRITISH COLUMBIA

Department of Medical Genetics

island health

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: DD / MMM / YY _____

Previous Name: _____ Date of Death (if applicable): _____

Personal Health Number: _____

I authorize: _____
(names of all doctors' offices, clinics, or hospitals holding health records)

to release the following health records to Drs. Laura Arbour and Anna Lehman, lead Investigators of the research study entitled "*Silent Genomes: Precision Diagnosis for Indigenous Families with Genetic Conditions*". This study has received ethics approval from the Research Ethics Boards at the University of BC/Children's & Women's Health Centre of BC, and Island Health.

Information Requested:

- ☐ **Genetic records/ test results:** _____
- ☐ **Family history/ pedigree:** _____
- ☐ **Biochemical test results:** _____
- ☐ **Medical imaging reports:** _____
- ☐ **Physician letters/consultations:** _____
- ☐ **Pathology reports:** _____
- ☐ **Autopsy/Coroner's reports:** _____
- ☐ **Other**:_____

I give consent for the research team to review my medical records to determine if I am eligible for this study. If I am eligible and sign a separate consent form to join the study, information from my medical records will be used for study purposes. If I am not eligible for the study or decide not to join, the research team will destroy all information pertaining to my medical records.

Participant's signature: _____ Date: _____

Representative's Name & Signature, *if needed* *(e.g. parent/guardian for minors, legal substitute decision-maker for dependent adults, or executor of estate for deceased patients):*

_____ Date: _____

Relationship to Participant (e.g. parent/guardian, executor of estate): _____