



### III. INFORMATION THAT MAY BE RELEASED

The people or agencies marked in Section IV below may view, copy, release, and exchange the information or records marked below. Please check all that apply to your needs now and in the future. This information may be shared verbally, in writing, and / or by email or fax.

Medical Information, including by not limited to operative, emergency, radiology, consultations, progress notes  
Genetic Testing Results  
Speech / Language Information  
Rehabilitation Information

Family Information, including by not limited to size of family, family income, family support  
Developmental Information  
Developmental Screening Information  
Other

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The following information will not be released unless you specifically authorize it by marking the relevant box below:

I specifically authorize the release of information pertaining to mental health diagnosis or treatment or psychological information (Welfare & Institutions Code, §§5328, et seq)

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### IV. APPLICABLE RECORDS

The records and imaging to be released may include (but are not limited to) the following:

*By checking these boxes, you are indicating that the person / agency listed in Section II may be in possession of the indicated test results. This helps the VHL Alliance make sure that it is collecting all the relevant material that you have released.*

Genetic Testing Results  
Brain and/or Spine Scans  
Retina (Eye) Imaging  
Hearing Test Results  
Skin Biopsy Results  
Lung Testing and Scans

Cardiovascular (Heart) Test Results  
Pheochromocytoma / Parganglioma Test  
Kidney Test Results, Scans, Pathology  
Digestive System Test Results  
Thyroid / Parathyroid Test Results, Scans, and Pathology  
Other

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### V. INFORMATION MAY BE EXCHANGED BY THE FOLLOWING PERSONS / AGENCY(IES)

I know that my healthcare team includes the physicians and / or agencies marked below.

*Again, this helps the VHL Alliance make sure all relevant material that you have released is collected. Please check all that apply to your needs now and in the future.*

Healthcare services

Primary Health Care  
Physician Specialist Provider  
Other

Social Services Agency

Social Worker  
Case Manager  
Other

Mental Health Services

Psychologist  
Physician / Psychiatrist  
Therapist  
Other

Family Resource and/or Regional Centers

Other Agency:

Case Manager

Administrative Staff

Family Support Worker

**VOLUNTARY:** I know that I am not required to sign this consent form. I can refuse to sign this consent form, and it will not affect the services received from any of the agencies listed on this form.

**LENGTH OF TIME:** This consent will be valid from the date that I sign this form until the date marked in the box below.

If no date is entered, the form will be valid for one year after the date that I sign.

**PURPOSE:** The purpose of this patient information request is for medical research only.

**WITHDRAWAL:** I know that I can withdraw this consent at any time. To withdraw my consent, I must send a written note to the person or agency in Section I. The withdrawal will be valid as soon as the person or agency receives my note, but it will not apply to information that has already been shared after I signed the consent form.

**SHARING OF INFORMATION:** I know that my information may be shared more than once by the persons and/or agency(ies) in Sections I and II. The information may no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). It may still be protected by other State and Federal laws.

**COPY:** A copy of this consent form will be as good as the original. I know that I have a right to obtain a copy of this consent form if I ask for one.

**ELECTRONIC SIGNATURE:** By typing my full legal name and date in the specified boxes below, I attest to the best of my knowledge that the information on this form is true.

Electronic Signature of Patient

Date (MM/DD/YY)

Electronic Signature of Parent / Guardian (if applicable)

Date (MM/DD/YY)

## PATIENT INSTRUCTIONS FOR SAVING & SUBMITTING THIS FORM:

1. Please save your completed and signed form, indicating the date it was signed in the file title: **YYYY.MM.DD - Patient's LastName, FirstName - release records from Person/Agency in Section II for MyVHL** example: 2016.11.04 - Doe, Jane - release records from Dr Jones for MyVHL

2. Please email your form to Josh Mann: Josh.Mann@vhl.org  
Email Subject: (\*\*same as the form file name\*\*)