S.C.N.I.R.

University of Washington
The Severe Chronic Neutropenia International Registry
1107 NE 45th Street, Suite 345
Seattle, WA 98105
Phone 206-543-9749 Or 800-726-4463
Fax 206-543-3668

PERMISSION TO DISCUSS PROTECTED HEALTH INFORMATION

– Completion of this form is optional –

Date:_____

Patient Name:_____ Date of Birth:_____

I, _____, authorize the Severe Chronic Neutropenia International Registry and all of its affiliated health professionals to **VERBALLY** and **IN WRITING** (**ON PAPER)** discuss information regarding my participation with the SCNIR Registry and my ongoing medical care with the following person(s) to whom I give permission to be involved and advised in all matters relating to my health care.

1. Name:_____ Relationship:_____

Home Phone:_____ Cell Phone:_____

2. Name:_____ Relationship:_____

Home Phone:_____ Cell Phone:_____

I understand that I may cancel this permission at any time (by writing to the SCNIR), but that cancelling it will not affect any information that has already been released.

I understand that I do not have to sign this form, and that I should only sign it if I want the SCNIR to share my information with someone (I authorize).

_____

Signature of Patient or Authorized Representative Date

_____

Relationship to Patient

_____

Reason patient is unable to sign*

**If signed by Authorized Representative, please also attach copies of supporting legal documentation.*