

**National Registry of Myotonic Dystrophy and Facioscapulohumeral  
Muscular Dystrophy Patients and Family Members**



**Authorization for Release of Medical 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 or  
MDA clinic about your muscle disease only.***

I authorize the National Registry of Myotonic Dystrophy and Facioscapulohumeral Muscular Dystrophy to obtain information from:

Provider name: \_\_\_\_\_ Provider name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

Fax: \_\_\_\_\_ Fax: \_\_\_\_\_

**TYPES OF RECORDS REQUESTED:** Initial diagnostic note    Last clinic note    DNA testing    EKG    EMG  
Muscle biopsy    Records that pertain to your muscular dystrophy

**SEND RECORDS TO:**    National Registry    **Phone:** (888) 925-4302  
601 Elmwood Avenue, Box 673    **Local Phone:** (585) 276-0004  
Rochester, NY 14642-8673    **Fax:** (585) 273-1255

**PURPOSE FOR THIS REQUEST:** Research  
**AUTHORIZATION VALID FOR:** One year from the date of authorization or \_\_\_\_\_ (insert date).

- I understand that:***
- My right to health care treatment is not conditioned on this 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.
  - If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
  - Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.

**Signature of Patient or Representative:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**Relationship to Patient (if requester is not the patient):** \_\_\_\_\_

***Please return this form to us so we can communicate directly with your  
physician, or if you prefer, you may provide it directly to your physician.***

Address: 601 Elmwood Avenue, Box 673, Rochester, NY 14642  
Phone: Toll-free 1-888-925-4302    Local 585-506-0004    Fax 585-273-1255  
E-mail [Dystrophy\\_registry@urmc.rochester.edu](mailto:Dystrophy_registry@urmc.rochester.edu)