

VA WEST HAVEN CSP530  
ACUTE RENAL FAILURE TRIAL NETWORK (ATN STUDY)  
FORM 14 - RELEASE OF INFORMATION

Hospital No.

Patient ID

Patient Initials

Date Form Completed (mm/dd/yy)

This form authorizes the disclosure of protected health information, as described below.

Patient's Name and Date of Birth

Patient's First Name

M.I.

Last Name

Date of Birth

 (mm/dd/yyyy)

What Information May be Disclosed?

Discharge Summary -----

Admission Date

Billing Record -----

Admission Date

Who May Disclose the Information?

Facility

Number & Street Address

City

State

Zip Code

Who May Receive and Use the Information:

Staff members, investigators, and researchers affiliated with the ARF Treatment Network Trial (VA CSP #530) or with the Veterans Health Administration.

Mail records and a copy of this form to:

ARF Treatment Network (ATN) Trial (CSP #530)  
c/o Mark Smith, PhD  
HERC  
VA Palo Alto Healthcare System  
795 Willow Rd (MPD 152)  
Menlo Park, CA 94025

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**Authorization Statement:**

I hereby authorize disclosure of the information described above. I understand the following:

1. The information will be used for research and to improve the quality of health care;
2. There is no expiration date for the authorization;
3. I may refuse to sign this authorization, and refusal will not affect my ability to participate in the ATN Trial;
4. I may revoke this authorization at any time by making a written request;
5. If I revoke this authorization, it will not apply to actions taken earlier.

\_\_\_\_\_  
Print Name of Patient

\_\_\_\_\_  
Signature of Patient

		/			/			(mm/dd/yy)
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Date Signed

Staff Initials

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