ID: _____

**DIABETES AUTOIMMUNITY STUDY IN THE YOUNG**

**Authorization for Release of Medical Information**

Subject name: _____ _____ _____
Last First MI

Date of birth of subject: _____/_____/_____
month day year

I agree to periodical review of my child's medical records to detect signs or symptoms of diabetes and other autoimmune disorders. I permit the release of medical information for the above-named subject at any time following the birth date stated above, for the duration of the Diabetes Autoimmunity Study in the Young. The information will be forwarded to:

Diabetes Autoimmunity Study in the Young
4200 East 9th Avenue
Box C-245
Denver, Colorado 80262

I hereby give permission to the Diabetes Autoimmunity Study in the Young to request medical information from the hospital(s) and physician(s) that have cared for my child as I have reported to the study. I hereby release the hospital(s) and physician(s) from any liability and all claims of any nature whatsoever pertaining to disclosure to this study of information contained in the medical records. It is understood that a copy of this consent is just as valid as the original. I authorize this for the length of the study unless revoked in writing by myself.

Signature of Subject's parent/guardian: _____

Print Name of Subject's parent/guardian: _____

Relationship to Subject: _____

Date: _____