Permission to Contact for Wisconsin Alzheimer's Disease Research Center

You may be eligible for a memory research study. Can research staff talk to you about their study about Alzheimer's disease and related memory disorders?

The HIPAA Privacy Rule requires this clinic to obtain your written permission to release your name and phone number to Dr. Sanjay Asthana and his research team at the University of Wisconsin–Madison so that they can contact you about taking part in this study.

If you agree that we can share your name and telephone number, this information will only be used to contact you to provide more information about this study. Your name and telephone number will not be shared with anyone other than the UW research team. This permission for the researchers ends after the release of your health information to the researchers.

If you decide that you do not wish to take part in the research study after giving permission to provide the researchers with your name and telephone number, the UW researchers will destroy this information. Whenever possible, your health information will be kept confidential. However, if you have given permission to share your information with recipients who are not covered by federal health information privacy laws, the health information they receive may no longer be protected under those federal laws and the recipients may be permitted to further share your information without your permission. As noted before, there are no plans to share your name and contact information with anyone other than the UW researchers.

You do not have to give your name and contact information if you don't want to. If you don't want to provide your name and contact information, it will not affect your health care at this clinic.

To give your permission for this clinic to give your name/phone number to Dr. Asthana's research team to contact you about taking part in his study, please:

1) **Print your name and phone number below.**
2) **Fill out the name and contact information of someone who knows you well below.**
3) **Fill out and sign the attached Medical Release form.**

Your name: ____

Phone number: (_____)_________________

Diagnosis (check one): _____AD ____MCI _____Healthy Control

In order to make sure we can get a hold of you, it is helpful for us to receive an Alternate Contact, or information about your Study Partner.

Name: ____

Address: ____

City:_____________________ State:_________ Zip:_____________

Phone: (___) ___________________ Email: _________________________________

Relationship to patient (check one):

Spouse/Partner Adult Child Other Relative Friend Other