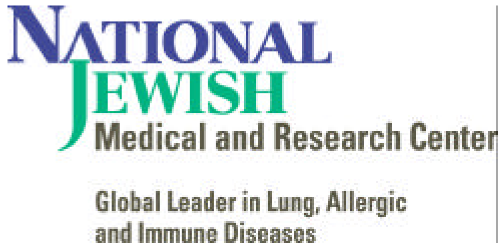

Please **print this form**, fill it out and either
FAX to: 303-270-2170
or **mail to**:
National Jewish Medical & Research Center
1400 Jackson St., K-333
Denver, CO 80206

National Jewish Medical and Research Center
Behavioral Research Center

PERMISSION TO CONTACT

By completing this form you are giving permission to the Behavioral Research Center and its members to possibly contact you in the future. Your name and information will be used only for contact purposes and will not be given to anyone else for any reason.

Your permission is voluntary. You may refuse or you may withdraw your permission at any time without penalty or loss of benefits which you/your child are otherwise entitled and without effect on future medical care at National Jewish Center.

I,______________________________, give permission to the Behavioral Research Center and all included members to contact me in the future regarding the possibility of participating in research projects at the National Jewish Medical and Research Center.

____________________________________ ________________________

Signature Date

Contact Information:

Parent Name______________________________________

Child Name_______________________________________ DOB______________

Phone____

Alternative Phone__________________________________

Address____

____

Other additional contact information:

HS 1669
Revised 26 February, 2004

This consent will expire on _______________________(4 years from the date this was signed).