

Dr. Peter J. Pommerville, Director of Research

**PERSONAL HEALTH INFORMATION  
RELEASE FORM**

I, the Undersigned, hereby consent to allow Can-Med to review my personal health information in Dr. Pommerville's medical records to determine if I may potentially be eligible for participation in a clinical study (as discussed with me by Dr. Pommerville).

I agree to have my name, current phone number and address, date of birth, information regarding enrollment in any previous studies as well as the medical condition I am being treated for under Dr. Pommerville's care to become a part of a database maintained by Can-Med and accessed only by authorized Can-Med personnel.

I understand that Can-Med will only collect information for the purpose described in this release form and that I may 1) request at any time to have my information removed from the database, and 2) remove my approval to access my personal health information held in Dr. Pommerville's medical records. This can be done by contacting Can-Med at the address or phone number noted above.

I understand that Can-Med will maintain my information in a confidential and secure manner. The information will be held until June, 2012.

**SIGNATURES**

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date of Birth

(Please use format, dd-mmm-yyyy – Eg. 29-Jan-1962)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date Signed

(Please use format: dd-mmm-yyyy – Eg 29-Jan-1962)

**Witnessed By:**

\_\_\_\_\_  
Witness Name

\_\_\_\_\_  
Date Signed

(Please use format, dd-mmm-yyyy – Eg. 29-Jan- 1962)

\_\_\_\_\_  
Signature

Form 036-01: V1 26-Oct-2007

Internal Use Only: Primary Diagnosis: \_\_\_\_\_

Internal Use Only: Receiver (Initials and Date) \_\_\_\_\_

Internal Use Only: Entered into DB (Initials and Date): \_\_\_\_\_