NEUROGENETICS CLINIC
INFORMATION RELEASE FORM

To: _____

Address: _____

_____

_____

This is to authorize the release of my medical records relating to Fabry disease to:

Neurogenetics Clinic
Massachusetts General Hospital
CRP Building North
5th Floor, Suite 5240
185 Cambridge Street
Boston, MA 02114
617-724-9620 (Fax)
617-726-5732 (Phone)

Patient Name: _____

Date of Birth: _____

Address: _____

_____

_____

Telephone: _____

Patient (or guardian) signature: _____

Date: _____