



Date _____

VA Biorepository Brain Bank/ALS Study
VA Boston Healthcare System
150 South Huntington Avenue
Boston, MA 02130

Patient Consent for Contact

RE: Patient Name _____ DOB _____

Below please find a signed authorization for the VA Biorepository Brain Bank/ ALS Study to contact me regarding current or future research projects in which I may be able to participate. Please forward by fax, by mail or leave for authorized hand pick-up the following information to the VA Brain Bank/ALS Study.

Contact person (if different from patient) _____

Telephone number _____

Address _____

Date of Diagnosis _____

Referred by _____ at _____
Facility

Thank you.

Sincerely,

Ann McKee, M.D.
Principal Investigator, VA Biorepository
(857)364-5707, office telephone
Secure Fax: (857)203-3074

For questions please call:
(857)364-6748
Toll free (866)460-1158

I herewith authorize the release of the information listed above to the VA Biorepository Brain Bank/ALS Study.

Signature of Patient or Authorized Representative

Date