

**Lung Screening Study  
Medical Record Release Authorization Form**

**[Letterhead of Screening Center]**

ASSURANCE OF CONFIDENTIALITY - All information which would provide identification of the individual will be held in confidence, will be used only for study purposes, and will not be disclosed or released to other than the study team, unless required by law.

**AUTHORIZATION TO OBTAIN INFORMATION  
FROM MEDICAL RECORDS**

I, \_\_\_\_\_ hereby authorize the release of information from medical records and staff of a health care facility where I have been seen. This information will be used for the Lung Screening Study being conducted by NAME OF SCREENING CENTER and the National Cancer Institute. I understand that I may revoke this consent at any time except to the extent that action has already been taken. I also understand that this authorization expires one year from the date of signature. I further understand that all information obtained will be held confidential, and will not be disclosed to anyone but the researchers conducting this study, except as otherwise required by law.

\_\_\_\_\_  
Signature of Participant

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

\_\_\_\_\_  
Date