MA1302420

REQUEST FOR RELEASE OF MEDICAL INFORMATION

I hereby request that medical information and/or medical records regarding my pregnancy and its outcome (including monitoring my baby for up to one year) be released to the NUVIGIL® (armodafinil) / PROVIGIL® (modafinil) Pregnancy Registry (Protocol C10953-9022).

NUVIGIL® (armodafinil) / PROVIGIL® (modafinil) Pregnancy Registry Coordinating Center
United BioSource Corporation
200 Pinecrest Plaza
Morgantown, WV 26505
866-404-4106 (phone) / 888-772-9396 (fax)
www.nuvigilpregnancyregistry.com / www.provigilpregnancyregistry.com

Participant Information

Printed Name of Participant: Date of Birth:

_____ _____

_____ _____

Signature of Participant (Only for Participants 18 Years Old and Older) Date

_____

Participant Address:

_____

_____

Phone # / Email:

_____

IRB ACKNOWLEDGEMENT
DATE 3-8-13
DISPOSITION: NO FURTHER ACTION NECESSARY

_____

Printed Name of Parent/Legal Guardian (For Participants Under 18 Years Old, If Applicable)

_____ _____

Signature of Parent/Legal Guardian (For Participants Under 18 Years Old, If Applicable) Date

For Registry CC use: Patient ID: