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,

Neil Kowall, M.D.
Principal Investigator, VA Biorepository
Secure Fax: (857) 203-3074

For questions please call:
Office Telephone: (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