Date_____

Cognition, Behavior, and Caregiver Burden in ALS
VA Boston Healthcare System – 151C
150 South Huntington Avenue
Boston, MA 02130

Patient Consent for Contact

RE: Patient Name_____ DOB_____

Below please find a signed authorization for the Cognition, Behavior and Caregiver Burden in ALS research study to contact me regarding current or future research projects in which I may be able to participate. Please forward the following information to study staff by fax, by mail, or leave for authorized pick-up.

Contact person (if different from patient)_____

Telephone number_____

Address _____

Date of Diagnosis_____

Referred by_____ at _____
Facility

Thank you.

Sincerely,

Christopher Brady, Ph.D.
Principal Investigator
(857) 364-2136, office telephone
*If faxing, please send to our secure fax: (857) 203-3074

For questions please call:
(857)364-2136

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