



MEDICAL INFORMATION RELEASE FORM

I HEREBY REQUEST THAT MEDICAL INFORMATION RELATED TO MY INFANT BE RELEASED TO:

Teva Migraine Pregnancy Registry Coordinating Center
301 Government Center Drive Wilmington, NC 28403
Phone number: 1-833-927-2605
Fax number: 800-800-1052
Email: TevaMigrainePregnancyRegistry@syneoshealth.com

RECORDS TO BE RELEASED FROM:

Name of Health Care Provider: _____

Name of Practice: _____

HCP Specialty: ☐ Pediatric HCP ☐ Other: _____
(Please specify)

Address: _____

Telephone number: _____ Fax number (if available): _____

Email (if available): _____

Comments: _____

Infant's Date of Birth: _____ Infant's Gender: ☐ Male ☐ Female

☐ Verbal consent given by Patient to Registry Associate over the phone on: _____
Date

Signature of Registry Associate obtaining verbal consent _____
Date

Printed/Typed Name of Infant _____

Printed/Typed Name of Infant's Mother _____

Signature of Infant's Mother (optional) _____
Date

Address of Infant's Mother: _____

IRB Approved at the
Protocol Level
Dec 15, 2020

Telephone Number of Infant's Mother:

Email of Infant's Mother (if available):