

	MEDICAL INFORMATION RELEASE FORM FOR PARTICIPANT	
---	---	---

IRB Approved at the
Protocol Level
Nov 08, 2023

**I HEREBY REQUEST THAT MEDICAL INFORMATION RELATED TO MY PARTICIPATION
IN THE **TEVA MIGRAINE PREGNANCY REGISTRY** BE RELEASED TO:**

Real World Coordinating Center
Syneos Health™
Phone Number: 1-833-927-2605
Fax Number: 800-800-1052
Email: TevaMigrainePregnancyRegistry@syneoshealth.com

To Be Released From:

Name of Health Care Provider (HCP):

Name of Practice:

HCP Specialty: ☐ Obstetric HCP ☐ Treating/Therapeutic HCP ☐ Other (specify):

Address:

Telephone Number:

Fax Number (if available):

Email Address:

Comments:

Participant Information for Participant ID # :

Name of Participant:

Date of Birth (dd-Mmm-yyyy):

Address:

Telephone Number:

Email Address:

Medical Information Release Form - Participant

Study Name: Teva Migraine Pregnancy Registry, Protocol Number:TV48125-MH-50037

Study Specific Version: 2.0_17Aug2023

Document ID: **5014.W04A.00**, Effective Date 29-Jun-2023

Filing requirement: Participant case file



MEDICAL INFORMATION RELEASE FORM FOR PARTICIPANT



☐ Verbal Consent given by Participant to Real World Coordinating Center Associate by telephone on (dd-Mmm-yyyy)

Signature of Real World Coordinating Center Associate obtaining verbal consent

Date

Signature of Participant (if consent not provided verbally)

Date

Medical Information Release Form - Participant

Study Name: Teva Migraine Pregnancy Registry, Protocol Number:TV48125-MH-50037

Study Specific Version: 2.0_17Aug2023

Document ID: **5014.W04A.00**, Effective Date 29-Jun-2023

Filing requirement: Participant case file