#30658922.0

IRB Approved at the
Study Level
May 13, 2021

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:

NUVIGIL® (armodafinil) / PROVIGIL® (modafinil) Pregnancy Registry Coordinating Center
Syneos Health
301 Government Venter Drive
Wilmington, NC 28403
1-866-404-4106 (toll-free telephone)
1-800-800-1052 (toll-free fax)
Email: NuvigilProvigilPregnancyRegistry@syneoshealth.com

RECORDS TO BE RELEASED FROM:

Name of Health Care Provider: _____

Name of Practice: _____

HCP Specialty: ☐ Obstetric HCP ☐ Pediatrician ☐ Other: _____ (please specify)

Address: _____

_____

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

Email (if available): _____

Comments: _____

_____

Participant Date of Birth: _____

☐ Verbal Consent given by Participant to Registry Associate over phone on: _____ Date

_____ _____
Signature of Registry Associate obtaining Verbal Consent Date

_____
Printed Name of Participant

_____ _____
Signature of Participant (optional) Date

_____
For Participants Under the Age of Majority, Printed Name of Parent/Guardian

_____ _____
For Participants Under the Age of Majority, Signature of Parent/Guardian (optional) Date

Address of Participant: _____

_____

Telephone number of Participant: _____

Email of Participant (if available): _____