

Permission to Disclose Form

Please provide your name, title(s), and affiliation(s) as you prefer them to be published on the Observational Medical Outcomes Partnership website and communications.

Name:	
Title:	
Affiliation:	
Email:	(if you would like this provided also)
Title:	
Affiliation:	
Email:	(if you would like this provided also)

Signed:

Date:

Once you have reviewed and signed the form, please email to Emily Welebob, OMOP Senior Program Manager, Research at ewelebob@fnih.org.