
	<p align="center">MEDICAL INFORMATION RELEASE FORM</p> <p align="center">FOR INFANT</p>	<p align="center">IRB Approved at the Protocol Level</p> <p align="center">Nov 08, 2023</p> 
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**I HEREBY REQUEST THAT MEDICAL INFORMATION RELATED TO MY
INFANT BE RELEASED TO:**

Teva Migraine Pregnancy Registry

Real World Coordinating Center

Syneos Health™

Phone Number: 1-833-927-2605

Fax Number: [1-800-800-1052](tel:1-800-800-1052)

Email: TevaMigrainePregnancyRegistry@syneoshealth.com

To Be Released From:

Name of Health Care Provider (HCP):

Name of Practice:

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

Address:

Telephone Number: Fax Number (if available):

Email Address:

Comments:

Participant / Infant Information for Participant ID# :

Name of Participant:

Participant's Telephone Number: Email address:

Participant's Address:

Name of Infant:

Infant's Date of Birth (dd-Mmm-yyyy):

Infant's Assigned Gender at Birth: ☐ Male ☐ Female

Study Name: Teva Migraine Pregnancy Registry, Protocol Number: TV 48125-MH-50037

Study Specific Version: v.2.0_17Aug2023

Document ID Document ID: **5014.W04B.00**, Effective Date 29-Jun-2023

Filing requirement: Participant case file

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☐ 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 _____