

CIRCLE OF FRIENDS CONSENT FORM

Purpose: To facilitate communication between patients and/or their significant other on issues of living with myasthenia gravis by sharing with and learning from others. It is also a connection for patients who may not have the opportunity to attend support meetings. You may have your name added or removed from the list at any time by informing our Chapter office.

Privacy laws require us to have your permission to publicly print your information. If you want to be added to the Circle of Friends list, please fill out the form below and return to:

**Myasthenia Gravis Foundation of America
Great Lakes Chapter
2680 Horizon Dr. SE, Suite 208
Grand Rapids, MI 49546**

Name: _____

Address _____

City: _____ **State:** _____ **Zip Code:** _____

Date of Birth: _____ **Contact Phone number:** _____

Email Address: _____

**I give permission for the publishing of the following: My name and my:
(Check all that Apply)**

My Age Home Address Phone # Email Address

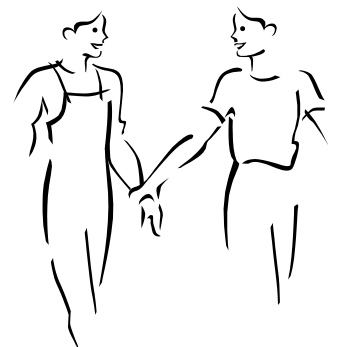
I give permission for the following items about me to be published:

My involvement with MG is as: _____
(i.e. patient, significant other/parent/child/friend of a patient)

My involvement is with the following form(s) of MG:

(i.e. Ocular, Generalized, MUSK+ MG, Congenital MG)

The MG I have involvement with is in and/or gone into remission.



My MG treatment involves:

(i.e. Mestinon, IVIG, Thymectomy, Imuran, Cellcept)

Other areas related to MG:

(i.e. still working, on disability, retired, going to school, was pregnant with MG, Parent with MG)

I hereby authorize the Great Lakes Chapter, MGFA to print my name, other information, phone number, and/or email address, as I have provided in this form, in association with the diagnosis of myasthenia gravis, a disclosure that may be viewed as use of protected health information.

I understand that a photocopy of this form will be considered as valid as the original. I understand that I may revoke authorization at any time by notifying the Great Lakes Chapter, MGFA at the chapter address, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.

I understand that by signing below, I acknowledge that I have read and understand this authorization.

Signature: _____ Date: _____