



INSTITUTE FOR  
**Child Health  
Research**

Affiliated with:  
The University of  
Western Australia and  
Princess Margaret  
Hospital for Children

STUDY NO \_\_\_\_\_

**WESTERN AUSTRALIAN PREGNANCY COHORT (RAINE) STUDY**

I, \_\_\_\_\_ hereby  
consent for personnel employed on The Western  
Australian Pregnancy Cohort Study (also known as The  
Raine Study) to contact my general practitioner and  
any other practitioners or agencies in order to  
obtain information or copies of medical and health  
records regarding my \_\_\_\_\_  
\_\_\_\_\_. I understand  
that any information so obtained will be used solely  
for research purposes, will remain strictly  
confidential and will not be released to any other  
persons. I also understand that I may withdraw this  
consent at any time without affecting the medical  
care of my child or his/her continuing participation  
in the study.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

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