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DATA REQUEST FORM

**Registry Name**

# Data Release Request Form

Only anonymised data will be released if this request is approved. All sections of this form must be completed.

Please submit your completed form electronically to customer.support@amplitude-clinical.com. The Committee will then be in contact in due course with any additional questions.

# Principal Requester Contact Details

Name: Email: Telephone: Position: Hospital: Organisation: Address:

Date of application:

**Data information**

Please list each individual who will have access to data:

**Name and role:**

**Name and role:**

**Name and role:**

**Name and role:**

Details of audit / data usage (intended use of data):

Data required:

Any other data specifics?