

REQUEST FOR RELEASE OF INFORMATION

The individual named below has enrolled in research at Kessler Foundation. A copy of the study consent form (which includes authorization for the release of Protected Health Information) is attached to this request form.

**Research Participant Name** *(printed)***:**

**No.:** **(Include Area Code) Participant Date of Birth:** ***MM/DD/YYYY***

**Participant ADDRESS:** ***(Include Zip Code)***

We request ***(name of institution or doctor releasing medical record)***  to disclose information from the participant’s medical recordsrelevant to their participation in research at Kessler Foundation. This release is limited to the portions of the participant’s medical records specified below:

**REQUESTED INFORMATION**

|  |  |  |
| --- | --- | --- |
| Emergency room record | Laboratory reports | Radiology images on CD |
| Clinic notes | Radiology reports (X-ray, CT, MRI, etc.) | EMS / Ambulance reports |
| History and Physical | Operative reports | Discharge summaries |
| Complete medical record  (all pages) | Other, specify: |  |

**DATES for RECORDS REQUESTED:**

**Range: From \_\_\_\_\_\_\_\_\_\_\_\_\_\_ To \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or Specific Dates (list): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**RELEASED TO**

|  |  |
| --- | --- |
| **Recipient Name** | **Recipient Signature** |
| **Recipient Telephone** | **Recipient Address (Line 1)**  **Recipient Address (Line 2)** |

**Thank you for your assistance with this request.**