RELEASE OF INFORMATION FORM

777 East Park Drive ☙ P.O. Box 8820
☙ Harrisburg, PA 17105-8820 ☙
Telephone: (717) 558-7819 ☙ Fax: (717) 558-7818
☙ Toll Free: (866) 747-2255 ☙

Send information to: *Name/Title: ______________________________
(name & address necessary) *Company: ______________________________
*Address: ______________________________
*Address: ______________________________
*City, State, Zip: ______________________________
FAX NUMBER: ______________________________

From: Physicians' Health Programs

RE: PARTICIPANT CONSENT FOR DISCLOSURE OF INFORMATION

*Participant Name: ______________________________

*Purpose or need for disclosure:
- ☐ Credentialing
- ☐ Statement Regarding Compliance
- ☐ Licensure (requires summary letter)
- ☐ Other: ______________________________

*Information to be disclosed:
- ☐ **Compliance Statement**
- ☐ **Quarterly Compliance Statements**
- ☐ **Summary of Participation**
- ☐ **Verbal Communication**

*Date consent expires: (month/day/year) ______________________________

THIS CONSENT IS SUBJECT TO REVOCATION AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE THEREON.

* ______________________________ * ______________________________
Participant Signature **Date**

***All letter fees must be paid in advance.**
Active cases: Compliance statements no charge. Summary letters $25.00
Closed cases: Compliance statements $25.00. Summary letters $50.00
RUSH or faxing of letters: $10.00 additional charge

AMOUNT $__________________

☐ Check is enclosed. (**<u>Please make check payable to Physicians' Health Programs or PHP</u>**.)
☐ Please charge my MasterCard __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ Exp.Date:___-___
☐ Please charge my VISA Card __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ Exp.Date:___-___

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Cardholder Authorization

Rev. 02/10

***INDICATES A REQUIRED FIELD**