Pharmacists' HEALTH Program

A Peer Assistance Monitoring Program of the Foundation of the Pennsylvania Medical Society

RELEASE OF INFORMATION FORM

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Mechanicsburg, PA 17050
Telephone: (717) 558-7819 Fax: (855) 933-2605
Toll Free: (866) 747-2255

Send information to:
(name & address necessary)

*Name/Title: _____
*Company: _____
*Address: _____
*Address: _____
*City, State, Zip: _____
Telephone Number: _____
FAX NUMBER: _____

From: Physicians' Health Program

RE: PARTICIPANT CONSENT FOR DISCLOSURE OF INFORMATION

*Participant Name: _____

***PURPOSE OR NEED FOR DISCLOSURE:**

- ☐ Credentialing
- ☐ Licensure (requires summary letter)
- ☐ Statement Regarding Compliance
- ☐ Other: _____

***INFORMATION TO BE DISCLOSED:**

- ☐ Compliance Statement
- ☐ Summary of Participation
- ☐ Quarterly Compliance Statements
- ☐ Verbal Communication

***MANDATORY* DATE CONSENT EXPIRES MUST BE A 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**

***MANDATORY* All letter fees must be paid in advance and included on this form.**

- ☐ **Active Cases:** Compliance Statements $10.00. Summary Letters $50.00.
- ☐ **Closed Cases:** Compliance Statements $50.00. Summary Letters $250.00.
- ☐ **RUSH** ***($10.00 additional charge)*** ☐ **FAX** ***($10.00 additional charge)***

AMOUNT $: _____

- ☐ I have funded my Affinity account for cost of letter.
- ☐ Please charge my VISA, MasterCard, Discover or American Express Card (circle one)

__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ Exp. Date: ___ - ___ Security Code: _____

Cardholder Name: _____

Billing Address: _____

NOTE: Charge will appear on your credit card statement from Affinity Solutions, Inc.

_____
Cardholder Authorization

***INDICATES A REQUIRED FIELD**

Revised 4.3.25