



Physicians' HEALTH Program

The Foundation of the Pennsylvania Medical Society

RELEASE OF INFORMATION FORM

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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