KESSLER FOUNDATION

1199 Pleasant Valley Way, West Orange, NJ 07052

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize ***(name of institution or doctor releasing medical record)*** to disclose to the person(s) or entity(ies) named below information from my medical records relevant to my participation in research at Kessler Foundation. This release is limited to the portions of my medical records specified below:

INFORMATION TO BE RELEASED

☐ 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:	☐ Other, specify:

DATES for RECORDS REQUESTED:

Range: From _____ **To** _____ **or Specific Dates (list):** _____

Research Participant Name *(printed)*: _____

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

Participant ADDRESS: *(Include Zip Code)* _____

RELEASED TO

_____ _____

Recipient Name **Recipient Signature**

_____ _____

Recipient Telephone **Recipient Address (Line 1)**

_____

Recipient Address (Line 2)

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information.

I understand that my health information may be shared with people and researchers at Kessler Foundation and associates of the sponsor(s), university, clinic or hospital who help with the research. The researchers may share this information with other people or organizations who are in charge of the research, others who are helping the research study to be done, those who pay for the research, or those who make sure that the research is done properly.

I can change my mind at any time and remove my approval to allow my information to be used in the research. If this happens, I must remove my approval in writing. Beginning on the date I remove my approval, no new information will be used for research. However, researchers may continue to use the information that was provided before I withdrew my approval. I also understand the investigator has the right to withdraw me from the study at any time.

If after signing this form, I want to remove my approval, I can contact the person(s) below. He/she will make sure the written request to remove my approval is processed correctly.

(Insert Contact Person Name, their Title, Address, Phone and Fax numbers-include ONLY names associated with the study team)

This approval for the release of my health information to Kessler foundation has no expiration date. However, as stated above, I can change my mind and remove my approval at any time. I may choose to remove my approval without penalty or loss of benefits to which I am otherwise entitled.

Questions should be directed to the research staff person who is reviewing this form with me. I can also call the Kessler Foundation Privacy Board – John DeLuca, Ph.D., ABPP at (973) 324-3572.

I hereby knowingly and voluntarily authorize the institution above to release my health information to Kessler Foundation.

Signature of Participant*	**Date**

❒ **Participant unable to sign due to arm impairments or authorization obtained by telephone (fill in date only above and provide a witness signature below)*

If individual is a minor or is otherwise unable to sign this Authorization, please complete the information below:

Signature of Representative* (authorized Legal Guardian, Health Care Agent or Other Authorized Personal Representative)	**Printed Name/Relationship** **Date**

❒ **Representative unable to sign due to authorization obtained by telephone (fill in name/relationship only above and provide a witness signature below)*

Signature of Witness	**Printed Name** **Date**