



Jefferson University Physicians

CONSENT TO RELEASE MEDICAL INFORMATION

THIS FORM EXPIRES ON: _____
(Insert date from Section II below)

COPY OF THIS CONSENT GIVEN TO PATIENT? Yes Patient Refused Copy

I. PATIENT IDENTIFICATION SECTION

Patient Name: _____
Date of Birth: _____ Date of Visit: _____
Address: _____

II. WRITTEN CONSENT SECTION

I, _____ hereby consent to the
(Insert Patient Name)
release of the following information from my medical records by _____
(Insert Name and Address of Physician or Facility)
to Edwin Daskewsky at the following address: _____
(Insert Name or Title of Individual or Organization Receiving Information)
Fax 215-732-2320

Specific Information to be Released:

Specific Purpose of Release:

This written consent is subject to revocation at any time by writing to the physician or practice which is to release the information except to the extent that this physician or practice has already acted in reliance on this consent. If not previously revoked, this consent will remain in force from _____ to _____

(Today's Date)

(Specify date consent will expire, not to exceed 120 days, or specify illness or treatment at the end of which consent expires. Insert expiration date at the top of this form.)

This consent form has been fully explained to me and I understand its contents. I have been informed of my right under Pennsylvania law to inspect material to be released, subject to the limitations imposed by Pennsylvania regulations. 55 Pa. Stat. section 5100.33.

Signature of Patient: _____ Date: _____

Signature of Legal Guardian, Next of Kin, Executor, Administrator, or other Legal Representative: _____ Relationship: _____ Date: _____

Witness: _____ Date: _____