Nurses' HEALTH Program
The Foundation of the Pennsylvania Medical Society

RELEASE OF INFORMATION FORM

400 Winding Creek Boulevard
Mechanicsburg, PA 17050
Phone: (717) 558-7823 ■ Fax: (855) 933-2605

*** INDICATES A REQUIRED FIELD**

Send information to:

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

FROM: Nurses' 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

***<u>MANDATORY</u>: Date consent expires must be a month, day, and year.** _____
(MM/DD/YYYY)

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

* _____ * _____
Participant Signature **Date**

***<u>MANDATORY</u>: <u>All letter fees must be paid in advance.</u>**

Active Cases:	☐ Compliance Statement $10.00	☐ Summary Letter $50.00	$ _____
Closed Cases:	☐ Compliance Statement $50.00	☐ Summary Letter $250.00	$ _____
Additional Fees:	☐ RUSH $10.00	☐ Fax $10.00	$ _____

☐ **I have funded my Affinity account for the cost of the letter.**
☐ **Please charge my credit card. (NHP accepts VISA, MasterCard, Discover, or American Express.)**

Credit Card #: _____ Exp. Date: _____ CVV: _____
Cardholder Name: _____
Billing Address: _____

_____
Cardholder Authorization

<u>IMPORTANT</u>: Charges will appear on your credit card statement from Affinity EHealth Inc.