Keystone CLINICAL STUDIES, LLC
BETTER MEDICINES THROUGH RESEARCH

920 Germantown Pike, Suite 102, Plymouth Meeting 19462
Tel: 610.277.8073 Fax: 610.277.8046

Authorization to OBTAIN Health Information

I, _____
(Name) (Date of Birth)
do hereby authorize the provider(s) identified below to release the following information from my health records. The information is limited to: (check all that apply)

____ Discharge Summary ____ Operative Report ____ Abstract ____ Pathology Slides

____ Laboratory Tests ____ Radiology Reports ____ Consults ____ Cardiac Studies

____ History and Physical ____ Pathology Reports ____ Progress Notes

____ Medication Record

Pertaining to my admission or outpatient treatment between _____ (specify dates). These records are required for the purpose of my participation in a clinical trial, and continuity of care. The information is to be released to:

Cherian Verghese, MD - Keystone Clinical Studies, LLC
920 Germantown Pike, Suite 102, Plymouth Meeting, PA 19462
Telephone: 610-277-8073 Fax: 610-277-8046

Provider Information
Name, Title, Organization: _____
Address: _____
Phone: _____ Fax: _____

I understand that my authorization shall remain effective for sixty (60) days from the date of my signature. I also understand that I may revoke this authorization (except to the extent that some action has been taken based on this authorization) at any time by writing to Dr. Cherian Verghese, MD at the above address.

I understand that this information may be reviewed by the Sponsor of the clinical trial or their representatives, the Institutional Review Board overseeing this study, and regulatory authorities. I understand that any disclosure of information may be subject to re-disclosure by the recipient and will no longer be protected by federal privacy regulations.

I have also been informed of my right, subject to Section 5110.5 of the Mental Health Procedures Act, 1976 to inspect the information and Section 8 of the Pennsylvania Drug & Alcohol Abuse Control Act, 1972 and the Confidentiality of HIV-Related Information Act, 1991, which specifically limit disclosure.

Signature of Patient, Parent or Authorized Representative Date

Signature of Witness Date