Keystone CLINICAL STUDIES, LLC
BETTER MEDICINES THROUGH RESEARCH

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Authorization to RELEASE Health Information

I, _____
(Name) (Date of Birth)
do hereby authorize Keystone Clinical Studies, LLC 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 _____ Clinical Trial Participation (and relevant information)

Pertaining to my admission or outpatient treatment between _____ (specify dates).
This release is required for the specific purpose of continuity of care.
The information is to be released to:

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

I understand that my authorization shall remain effective for ninety (90) 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 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.

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.

Signature of Patient, Parent or Authorized Representative Date

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Signature of Witness Date