



**K**ESSLER  
**M**EDICAL  
**R**EHABILITATION  
**R**ESearch AND  
**E**DUcATION  
**C**ORPORATION

A Not For Profit Medical Research Organization

**CONSENT TO RELEASE MEDICAL RECORDS**

I, \_\_\_\_\_, hereby consent to the release of my medical records to:

Name: **Elie Elovic, M.D.**  
**Director, Traumatic Brain Injury Research**

Address: **Kessler Medical Rehabilitation Research & Education Corporation**  
**1199 Pleasant Valley Way, West Orange, NJ 07052**

Purpose of disclosure: New patient \_\_\_\_\_

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I understand that my consent herein given is subject to revocation at any time, except to the extent that action has been taken in reliance thereon.

This consent is subject to revocation at any time by me and is automatically revoked after one year from the date hereof.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Agent or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient