COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS

Professional Health Monitoring Programs
P.O. Box 10569
Harrisburg, PA 17105-0569

Telephone: 717-783-4857
Fax: 717-772-1950
Email: ra-stphmp@pa.gov

Records Release Authorization

I, _____ hereby give my consent to: the Professional Health Monitoring Programs (PHMP), Bureau of Professional and Occupational Affairs to disclose information from my PHMP record to:

Attorney Name:_____ **Telephone:**_____

Address:_____

The purpose of the disclosure will be for PHMP to verify my enrollment in the PHMP.

I understand that I have no obligations whatsoever to disclose any information from my PHMP record and that I may revoke this consent at any time by notifying the PHMP case manager prior to release of the records; and/or specifying a date, event or condition upon which my consent will expire without revocation, which I have done below.

This consent shall expire _____.
(Date, Time, Event or Condition)

Participant Signature **Date** **Witness Signature** **Date**

Notice: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.