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:

Provider Name: Foundation of the Pennsylvania Medical Society – Nurses' Health Program (PA-NHP)

Provider Address: 400 Winding Creek Blvd., Mechanicsburg, PA 17050 **Telephone**: 888-647-4968

to disclose to the Professional Health Monitoring Programs (PHMP), information limited to:

1. My presence in treatment: to include the estimated length of treatment; type of treatment services provided; attendance; and date and type of treatment termination.
2. My prognosis: to include diagnosis; provider's opinion of how treatment will or will not benefit the client; provider's recommendations regarding the client's continuation with the treatment.
3. Nature of the project: to include purpose and philosophy of the project; the program structure, methodology of treatment and treatment models utilized; services offered; and recommendations for supportive services and support groups.
4. Brief description of my treatment progress: to include progress or lack of progress as it relates to recovery in general; cooperation or lack of cooperation with the treatment plan and the facility rules, and acceptance of condition.
5. Short statement regarding relapse: to include any relapses, frequency of relapses, positive drug tests.

I understand that the information disclosed will be used for the sole purpose of verifying and monitoring my treatment to determine my eligibility for continued participation in the PHMP. This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. To revoke, I must notify the PHMP directly to specify the effective date of revocation. Without such notice of revocation, the consent shall automatically expire upon termination of my board consent agreement or order.

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.

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

Provider Name: Foundation of the Pennsylvania Medical Society – Nurses' Health Program (PA-NHP)

I understand that the information disclosed will be used solely for the purpose of verifying and monitoring treatment and recovery, in order to determine my eligibility for continued participation in the PHMP. The information will be limited to a brief description of my enrollment history, progress, and compliance with the board and/or program, to include an assessment by the board and/or program case manager of my motivation and commitment to recovery.

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 except to the extent that action has been taken in reliance thereon. To revoke, I must notify the PHMP directly to specify the effective date of revocation. Without such notice of revocation, the consent shall automatically expire upon termination of my board consent agreement or order, unless otherwise specified below:

_____
(Date, Time, Event or Condition)

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

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