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
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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:

Organization/Agency Name:_____**Telephone:**_____

Address:_____

for the sole purpose of verifying date(s) of my enrollment in the PHMP and my status in the program.

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**

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.