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

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

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Records Release Authorization

I, ____ give my consent to the Professional Health Monitoring Programs (PHMP), Bureau of Professional and Occupational Affairs to disclose the results of the drug and alcohol and/or mental health evaluation completed by the PHMP-approved evaluator to the:

Board Name: ____

Board Address:____

The purpose of the disclosure of this information is to enable the Board to make an informed decision regarding my application for licensure.

I understand that I have no obligations whatsoever to disclose any information and I may revoke this consent at any time by notifying the PHMP case manager in writing prior to release of the information; 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 one year from date of the applicant's signature or as otherwise indicated below.

____
Date, Time, Event or Condition of Expiration

Applicant Signature	**Date**	**Witness Signature**	**Date**