Health Professionals Services Program

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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PLEASE PRINT

Participant Name: First Middle Last				**DOB:**
Party: Attorney	**Attorney Name:**	**Agency:**		
Phone:		**Fax:**		
Address:		**City:**	**State:**	**Zip:**

THIS RELEASE OF INFORMATION IS: ☐ New ☐ Replacing ☐ Renewal

PURPOSE OF DISCLOSURE: I am asking HPSP to provide to my attorney for the purposes of legal representation.

INFORMATION TO BE DISCLOSED FROM HPSP TO THE ATTORNEY:

Monitoring Data (open and closed cases)	X
Verbal exchange of information	X

I UNDERSTAND THAT:

- This authorization expires at the end of one year from the date of signature, unless expressly removed in writing earlier.
- I may revoke this authorization at any time by notifying HPSP and the providing individual/organization in writing, and it will be effective on the date notified except for information that has already been released under this authorization.
- I have asked HPSP to release the data;
- I understand that although the data are classified as private at HPSP, the classification/treatment of the data at HEALTH PROFESSIONALS SERVICES PROGRAM may not be the same and is dependent on laws or policies that apply to THIRD PARTIES.

PARTICIPANT SIGNATURE: _____ **DATE:** _____