STATE OF MINNESOTA

HEALTH PROFESSIONALS SERVICES PROGRAM

1380 Energy Ln, Ste 202, St Paul, MN 55108- Phone: 651-643-2120;Fax: 651-643-2163

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

This authorization meets HIPAA guidelines - -Facsimile and photocopies valid as original.

PURPOSE OF DISCLOSURE:

As a participant in HPSP, you are being asked to authorize HPSP to receive the following information about you for the purpose of determining/maintaining eligibility or participation in HPSP, and/or for obtaining information necessary to establish and implement a Participation Agreement and Monitoring Plan. You are not legally obligated to release this information to HPSP; however, if you do not release this information, HPSP will close your file and make a report to your licensing authority.

FACILITY/AGENCY/PERSON information will be released to or received from:

This area for HPSP completion- internal use only

☐ *Y* ☐ *6mos* ☐ *Q* ☐ *M* ☐ *1X* ☐ *None*

○ **New** ○ **Replacing** ○ **Renewal**

Type of Authorization: Attorney

Agency/Facility:

Contact Person Credentials:

Mailing Address:

Phone: **Fax:** **City:** **State:** **Zip:**

PARTICIPANT IDENTIFYING DATA:

First Name: **Middle Name:** **Last Name:**

Date of Birth: **Maiden/Former/Alias Names:**

PARTICIPANT AUTHORIZES the verbal and written exchange of information of the following information (information created before, and up to one year after, the date of consent):

From the above noted agency/person(s)TO HPSP:

Medical History	XXX	Aftercare Plan/ Continuing Care	XXX
Psychiatric/Psychosocial History/ Treatment	XXX	Work Quality/ Ability	XXX
Chemical History/Assessment/Treatment	XXX	Drug screens/other compliance (if applicable)	XXX
Admission/Discharge/Transfer Summary	XXX	Other:	
Quarterly reports re diagnosis, active symptoms, treatment, meds, work restrictions, progress			

FROM HPSP to the above noted agency/person(s):

Monitoring and Compliance Data	XXX	Data subject to Minn. Stat. § 214.35 (closed cases)	XXX
Monitoring Plan	XXX	Other:	

I UNDERSTAND THAT:

- This authorization expires at the end of one year from the date of consent, unless expressly revoked in writing earlier.
- I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken.
- The information provided to HPSP will be accessible to HPSP, its employees, its medical consultants, and its legal counsel at the Minnesota Office of the Attorney General.
- Communications resulting from this authorization will reveal that I have been referred to HPSP and/or that I am being monitored by HPSP.
- The information provided to HPSP will be forwarded to the appropriate licensing authority under the following circumstances: if I fail to meet HPSP eligibility requirements, if I am discharged or reported to my licensing authority for non-cooperation, noncompliance with the terms of a Participation Agreement/Monitoring Plan, if I withdraw from the program without fulfilling my Participation Agreement/Monitoring Plan, or if allegations are made that I have committed violations of my practice act that are outside the authority of HPSP. If a licensing authority uses the data as a basis for corrective or disciplinary action, the information could become public.
- The covered entity for whom HPSP is requesting information from may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization form.
- I can request that information HPSP receives about me after the date of my signed Participation Agreement be forwarded to me or to those I authorize in writing.
- HPSP may release information when failure to make the data accessible is likely to present a clear and present danger to public health or safety pursuant to Minn. Stat. § 13.41, subd. 6. Information may also be released pursuant to a lawful court order or subpoena issued by law enforcement agencies, the courts or other regulatory agencies. Subsequent release of this data may result in the data no longer being protected by the HIPAA Privacy Rule.

Participant Signature: **Today's Date:**

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