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:

☐New ☐Replacing ☐Renewal

PURPOSE OF DISCLOSURE: As a current or former enrollee or participant in HPSP, I am asking HPSP to provide data HPSP received about me to my attorney for the purposes of legal representation.

INFORMATION TO BE DISCLOSED FROM HPSP TO THE ATTORNEY:

Information	
Monitoring Data (open and closed cases)	X
Substance Use Assessment and Treatment Records (if applicable)	X
Verbal exchange of information	X

Classification of data is subject to Minn. Stat. 214.35

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.

PARTICIPANT SIGNATURE: ____ **DATE:** _____________________