Health Professionals Services Program

1360 Energy Park Drive, Suite 220
St Paul MN 55108
phone: 651-642-0487
fax: 651-797-1380
website: mn.gov/boards/hpsp/
email: hlbhpsp@state.mn.us

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PLEASE PRINT

Participant Name: First Middle Last			**DOB:**
Regulatory Board/Agency:	**Contact Person:**		
Phone:	**Address:**		
☐New ☐Replacing ☐Renewal	**City:**	**State:**	**Zip:**

PURPOSE OF DISCLOSURE: As a current or former enrollee or participant in the Health Professionals Services Program (HPSP), I request HPSP provide the following information to the above noted regulatory board/agency for consideration of the status of my license.

INFORMATION TO BE DISCLOSED FROM HPSP TO THE BOARD/AGENCY:

Monitoring Data (opened and closed cases)	X	Participation Agreement (closed cases)	X
Substance Use Disorder Assessment and Treatment Program Records	X	Verbal Information	X

Classification of data is subject to Minn. Stat. 214.35

HPSP DATE STAMP

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**: _____