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:**
Closed Case	**Agency/Individual:**		
Phone:	**Contact Person:**		
Fax:	**Address:**		
	City:	**State:**	**Zip:**

PURPOSE OF DISCLOSURE: As a former enrollee or participant in the Health Professionals Services Program (HPSP), I authorize HPSP to provide the following data about me to the agency listed above for the purpose of (describe):

Authorization is valid only when this section is completed.

INFORMATION TO BE DISCLOSED FROM HPSP TO THE ABOVE IDENTIFIED AGENCY/INDIVIDUAL:

Participation Agreement and Monitoring Data	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:** _____