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: Credentialing	**Agency:**		
Phone:	**Contact Person:**		
Fax:	**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 am asking HPSP to provide the credentialing entity with information about my participation in HPSP to assist in determinations about my credential status.

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

Summary of Participation / Monitoring Compliance	X	Verbal Exchange of Information	X	Closed Case Status	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:** _____