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:**
Family Member	**Contact Person:**		
Phone:	**Address:**		
☐New ☐Replacing ☐Renewal	**City:**	**State:**	**Zip:**

PURPOSE OF DISCLOSURE: As an enrollee or participant in the Health Professionals Services Program (HPSP), you are authorizing HPSP to release information to your family member about your participation in HPSP.

INFORMATION TO BE EXCHANGED BETWEEN HPSP AND THE ABOVE IDENTIFIED FAMILY MEMBER:

Verbal Exchange of Information	X	Monitoring Data	
Other (specify)			

(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.
- The information provided to HPSP may be accessible to HPSP medical consultants and other providing organizations authorized to exchange information.
- The information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
- The information provided will be forwarded to the appropriate regulatory authority if I: a) fail to meet HPSP admission criteria; b) violate the terms of my Participation Agreement; c) leave or am discharged from the program except upon fulfilling the terms for successful completion of the program as set out in the Participation Agreement; d) cause patient harm; e) unlawfully substitute or adulterate medications; f) write a prescription in the name of a person or animal for my personal use; g) alter a prescription without the knowledge of the prescriber for the purpose of obtaining the drug for personal use; h) unlawfully use a controlled or mood altering substance or use alcohol while providing patient care or during a period of time in which I may have been contacted to provide patient care or is otherwise on duty; or i) if there are allegations I have been committed violations of my practice act that are outside the authority of HPSP.

PARTICIPANT SIGNATURE: _____ **DATE:** _____