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:**
Provider:	**Agency:**		
Phone:	**Contact Person:**		
Fax:	**Address:**		
☐New ☐Replacing ☐Renewal	**City:**	**State:**	**Zip:**

PURPOSE OF DISCLOSURE: As an enrollee or participant in the Health Professionals Services Program (HPSP), you are being asked to authorize HPSP to obtain data for the purposes of determining your eligibility for HPSP services, to establish and implement a Participation Agreement, and to provide ongoing monitoring services. You are not legally obligated to release this information to HPSP; however, if you fail to release the information, HPSP will discharge you and make a report to your regulatory board.

INFORMATION TO BE DISCLOSED BETWEEN HPSP AND THE ABOVE IDENTIFIED PROVIDER:

Medical History, Assessment, Treatment and Status	X	Verbal Exchange of Information	X
Mental Health History, Assessment, Treatment and Status	X	Progress Notes/Continuing Care Plan	X
Substance Use History, Assessment, Treatment and Status	X	Work Quality or Ability	X
Monitoring Data	X	Toxicology Screen Results	X
Quarterly reports about: diagnoses; continuing care; treatment compliance and progress; work ability; and work quality			X

HPSP DATE STAMP

Classification of data subject to Minn. Stat.

I UNDERSTAND THAT:

- This authorization expires at the end of one year from the date of consent, 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 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.
- HPSP may release data to other persons and government entities who are authorized to review data, investigate specific conduct, or take other legal action.

PARTICIPANT SIGNATURE: _____ **DATE**: _____