MINNESOTA
HEALTH PROFESSIONALS
SERVICES PROGRAM

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email: hlbhpsp@state.mn.us
website: mn.gov/boards/hpsp/

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: I request HPSP provide the following monitoring data, which is classified as private data, 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
Verbal Information	X		

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;
- I have asked HPSP to release the data;
- I understand that although the data are classified as private at HPSP, the classification/treatment of the data at noted regulatory board/agency may not be the same and is dependent on laws or policies that apply to the noted regulatory board/agency.

PARTICIPANT SIGNATURE: _____ **DATE**: _____