MINNESOTA
HEALTH PROFESSIONALS
SERVICES PROGRAM

1360 Energy Park Drive, Suite 220
St Paul MN 55108
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website: mn.gov/boards/hpsp/
email: hlbhpsp@state.mn.us

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PLEASE PRINT

Participant Name: First Middle Last			**DOB:**
Party: Employee Health	**Agency:** Allina Health EHS/EAP		
Phone: 763-236-3716	**Contact Person:** Katrina Arizmendi		
Fax: 763-236-7277	**Address:** 4050 Coon Rapids Blvd NW Suite 315		
☐ New ☐ Replacing ☐ Renewal	**City:** Coon Rapids	**State:** MN	**Zip:** 55433

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. I am authorizing HPSP to provide Employee Health Services with information about my participation in HPSP to assist in determining my ability to practice safely.

INFORMATION TO BE EXCHANGED BETWEEN HPSP AND THE EMPLOYEE HEALTH PROGRAM:

Work Status, Quality and Ability	X	Toxicology Screen Results	X
Fitness for Duty Evaluation	X	Monitoring Data	X
Status of Medical and Psychiatric Disorders	X	Verbal Exchange of Information	X
Work Restrictions	X	Status of Substance Use Disorder and Continuing Care	X

HPSP DATE STAMP

Classification of data is subject to Minn. Stat. 214.35

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:** _____