MINNESOTA
HEALTH PROFESSIONALS
SERVICES PROGRAM

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St Paul MN 55108
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email: hlbhpsp@state.mn.us

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PLEASE PRINT

Participant Name: First Middle Last			**DOB:**
Party: Out of State Monitoring Program	**Agency:**		
Phone:	**Contact Person:**		
Fax:	**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 party for consideration of the status of my license.

INFORMATION TO BE EXCHANGED BETWEEN HPSP AND THE ABOVE IDENTIFIED PARTY:

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

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:**_____