MINNESOTA 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:**
Party: Pharmacy	**Organization:**		
Phone:	**Contact Person:** Pharmacist in Charge		
Fax:	**Address:**		
☐ New ☐ Replacing ☐ Renewal	**City:**	**State:**	**Zip:**

PURPOSE OF DISCLOSURE: You are authorizing HPSP to obtain medical records for the purposes of determining your eligibility for HPSP services, to establish and implement a Participation Agreement, and to provide ongoing monitoring services.

INFORMATION TO BE DISCLOSED FROM THE ABOVE NAMED ORGANIZATION TO HPSP:

Service dates from _____/_____/_____ to one year from the date of signature.

Medical History, Assessment, Treatment and Status	X	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	Admission/Discharge/Transfer Summaries	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.
- 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 law. Data obtained by HPSP is subject to Minnesota Statutes chapter 13 and section 214.35

PARTICIPANT SIGNATURE: _____ **DATE:** _____