MINNESOTA HEALTH PROFESSIONALS SERVICES PROGRAM

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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Participant Name: First Middle Last			**DOB:**
Provider: Substance Use Assessor/Treatment Provider	**Agency:**		
Phone:	**Contact Person:**		
Fax:	**Address:**		
☐New ☐Replacing ☐Renewal	**City:**	**State:**	**Zip:**

PURPOSE OF DISCLOSURE: 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 the above-named provider with private monitoring data concerning my participation in HPSP to assist in determining my ability to practice safely.

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 Disorder 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

I UNDERSTAND THAT:

- My decision to allow release of the data to the above-named provider is voluntary;
- HPSP wants to release the data to assist in determining my ability to practice safely;
- Although the data are classified as private at HPSP, the classification/treatment of the data at the above-named provider may not be the same and is dependent on the laws or policies that apply to above-named provider;
- I give HPSP permission to discuss the data released by this consent with above-named provider;
- 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;
- HPSP may release data to other persons and government entities who are authorized to review data, investigate specific conduct, or take other legal action. 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 governed by Minnesota Statutes chapter 13 and section 214.35.

PARTICIPANT SIGNATURE: _____ **DATE**: _____