IBH | POPULATION HEALTH SOLUTIONS
MONITORING

Consent to Release, Use and Exchange of Information (#1)

1. Licensee Name: _________________________________ Date of Birth: _____________________

2. I, _______________________________________ , authorize IBH Solutions also known as the Delaware Professionals' Health Monitoring Program ("Program") to obtain, release, use and exchange my confidential health treatment information including, but not limited to, my use of prescription medication or use of impairing or mood altering substances or medications with addictive potential, my drug, alcohol and mental health treatment records from the Program and/or the status of my participation in the Program to the persons or entities identified below [re-release between the below listed individuals or entities is not authorized in accordance with 42 CFR Part 2]:

*Complete and **initial all lines that pertain to you;** Initial for either Nursing or Medical Board, but not both)*

3. _____ **Deputy Director**______________________________
Initial (Division of Professional Regulation)

4. _____ **Executive Director Board of Nursing**______________________________
Initial (Board Executive Director)

5. _____ **Executive Director Board of Medical License and Discipline**______________________________
Initial (Board Executive Director)

6. _____ ______________________________
Initial (Your Third-Party Evaluator – The Third-Party Evaluation is the Mental Health/Chemical Dependency evaluation completed to determine care requirements)

7. _____ **Nationwide Medical Review Officer**______________________________
Initial (Medical Review Officer)

8. _____ **MROEXPRESS**______________________________
Initial (Medical Review Officer)

9. _____ ______________________________
Initial (Other State Monitoring Board, if applicable)

10. _____ Medtox Diagnostics, St. Paul, MN______________________________
Initial (Drug Testing Facility - The only information to be released to Medtox is licensee name, address, drug panel and testing schedule)

11. _____ ______________________________
Initial (Dentist: Name, Address and Phone Number)

12. _____ ______________________________
Initial (Primary Care Physician: Name, Address and Phone Number)

13. _____ ______________________________
Initial (Treatment Provider: Name, Address and Phone Number)

14. _____ ______________________________
Initial (Treatment Provider: Name, Address and Phone Number)

15. _____ ______________________________
Initial (Treatment Provider: Name, Address and Phone Number)

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulation (42 CFR, Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute the patient.

IBH Monitoring
1220 SW Morrison St. Suite 600
Portland, Oregon 97205-2126
1-855-575-9351
delawaremonitoring.com

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The information to be released, used, exchanged and/or disclosed is:
Each item must be initialed

_____	Alcohol, Drug or Mental Health evaluation/assessment	_____	Drug testing collection site reports
_____	Progress notes	_____	Drug testing laboratory reports
_____	Treatment plan(s)	_____	Medical Records
_____	Discharge summary	_____	Employer Information
_____	Summary of Services Rendered	_____	Board referral information
_____	Attendance reports	_____	Collateral reports
_____	Prescription medications including medications with addictive, mood altering and/or impairing potential	_____	Compliance with Monitoring Agreement
		_____	Other: ___________________________

The disclosures authorized in this consent are to: monitor, coordinate and ensure compliance with the Program.

I understand that my alcohol and/or drug treatment and mental health records are protected under federal and state laws and regulations (42 CFR Part 2,) governing confidentiality of alcohol and drug abuse patient records and protected health information records generally, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke my consent to release such records at any time except to the extent that prior action has been taken in reliance upon it. I understand that for my revocation of consent to be in effect, it must be in writing. The DPR receives a regular report listing all active licensees in the Program. I understand that, if I revoke my consents, my name will no longer be on the active list and the DPR will know that I have revoked consent because they will not receive any notification of my completion of or termination from the Program.

I authorize the disclosure, use and re-release by the Program of my alcohol, drug and/or mental health treatment records, which records are protected as noted above. I further authorize the Program to release any other protected health information which it has received pursuant to a valid release of medical information form which I have signed.

I understand if I report abuse of a child or an elder or that I intend to harm myself or others, my confidentiality will be broken, and action will be taken in accordance with federal and state laws and regulations.

If not previously revoked, this Consent will automatically expire the later of one year from the date of signing or my successful completion of the Program.

DO NOT RETURN THIS CONSENT INCOMPLETE – PLEASE CALL WITH ANY QUESTIONS

____

Full Legal Signature of Licensee *OR* Licensee's Authorized Representative	Relationship to Licensee	Date

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