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

1. Licensee Name: _____ Date of Birth: _____

2. I, _____, authorize Reliant Behavioral Health aka as the Delaware Professionals' Health 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]:

(C*omplete and **initial all lines that pertain to you**-either Nursing or Medical Board, but not both)*

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

4. ____ Initial **Executive Director Board of Nursing**
(Board Executive Director)

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

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

7. ____ Initial **I3Screen Medical Review Officer**
(Medical Review Officer)

8. ____ Initial _____
(other state monitoring board, if applicable)

9. ____ Initial **Medtox Diagnostics, St. Paul, MN**
(Drug Testing Facility **name** and **address**) the only information to be released to Medtox is licensee name, drug panel, and testing schedule).

10. ____ Initial _____
(Dentist **name** and **address** and **phone #**)

11. ____ Initial _____
(Primary Care Physician **name** and **address** and **phone #**)

12. ____ Initial _____
(Treatment Provider **name** and **address** and **phone #**)

13. ____ Initial _____
(Treatment Provider **name** and **address** and **phone #**)

14. ____ Initial _____
(Treatment Provider **name** and **address** and **phone #**)

RBH Monitoring Programs
1220 SW Morrison St. Suite 600
Portland, Oregon 97205-2126
1-855-575-9351

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 protect 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. The DPR receives a regular report listing all active licensees in the Program. I understand that if I revoke my consents that 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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