

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]:

(Complete and **initial all lines that pertain to you**-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)

The information to be released, used, exchanged and/or disclosed is:

Each item must be initialed

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