
42 CFR – Part 2 and CFR Parts 160 & 164
RECORDS RELEASE AUTHORIZATION DENTIST

I, _____, give my consent to the Pennsylvania Nurse Peer Assistance Program (PNAP) Case Manager to disclose information from my PNAP record to:

_____

(Dentist name, address, phone number)

for the sole purpose of maintaining my participation in the PNAP program in good standing through monitoring of my treatment and recovery process.

I understand that the information disclosed **will be used solely for the purpose of verifying and monitoring treatment and assisting me in my recovery,** in order to continue my participation in PNAP. The information will be limited to that required to provide a factual context in which effective evaluation/treatment can take place.

I understand that I have no obligations whatsoever to disclose any information from my PNAP record and that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon, by notifying my PNAP Case Manager in writing; specifying the effective date of revocation. Without such notice of revocation, this consent shall automatically expire upon termination of my involvement in the PNAP program.

_____ _____

DATE SIGNED PARTICIPANT SIGNATURE

_____ _____

DATE SIGNED WITNESS SIGNATURE

Revised 9/9/15 KS