42 CFR – Part 2 and CFR Parts 160 & 164
RECORDS RELEASE AUTHORIZATION PHYSICIAN/SPECIALIST

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

_____

(Physician/Specialist name, address, phone number)

for the sole purpose of maintaining my participation in the PNAP program. The information will be limited to:

- A summary of my communications with the PNAP program representative;
- The results of my required evaluations and recommendations;
- Verification of my participation in the PNAP program;
- Verification of my status in good standing;
- Notification of any practice limitations currently required;
- Information about the PNAP program;
- Any contract violations, relapses, or positive ROB results.

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