



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

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

(Psychiatrist 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.

- 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