



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

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

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(Nursing School Representative name, address, phone number)

for the sole purpose of maintaining my participation in the PNAP program in good standing through monitoring of my employment and recovery process. This information will be limited to:

- Verification of my cooperation with the PNAP program;
- The results of my evaluation with a PNAP approved evaluator;
- Verification of my compliance status;
- Notification of any practice limitations currently required;
- Information about the PNAP program.

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.

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DATE SIGNED

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PARTICIPANT SIGNATURE

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DATE SIGNED

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WITNESS SIGNATURE