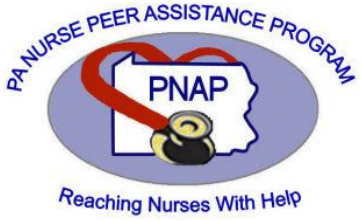

Consent to Release Confidential Information

Participant Name: _____ Date of Birth _____

PA Nursing License #: _____

I hereby authorize the Pennsylvania Nurse Peer Assistance Program (PNAP) to release the information indicated below from my PNAP record to:

Name/Credentials:_____

Relationship/Organization: _____

Address _____

Phone number _____Email Address _____

This consent includes the following information:

• Verification of my participation in PNAP	• Notification of practice restrictions
• A copy of my PNAP Contract	• Summary of communications with PNAP representative
• Evaluation results and recommendations	• Substance use history and drug screen outcomes. (physical drug screen results will not be released)
• Information about program requirements	• Other, as described below

Other: _____

This information will be released for the purpose of my participation and monitoring in PNAP.

I understand that this document authorizes the release of information that may be confidential under PA and of Federal law including 42 C.R.F. part 2.

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.

_____ _____ _____

Print Name Signature Date