TEXAS PEER ASSISTANCE PROGRAM FOR NURSES

Print Name_____/case#_____

CONSENT TO DISCLOSE INFORMATION BETWEEN TPAPN AND ACADEMIC PROGRAM

NOTE: This authorization/consent form ("Authorization") is to be used only exchange of information between the Texas Peer Assistance Program for Nurses, hereafter referred to as "TPAPN," and nursing academic program.

I understand a condition of my participation TPAPN is that I authorize TPAPN to use and disclose my Protected Health Information ("PHI") to any nursing academic program in which I am enrolled. I further understand that if I enroll in other nursing academic programs, I will need to execute additional authorizations. Nurses who decline to sign this Authorization or such additional authorizations are not eligible to participate in TPAPN.

I, (print name)_____authorize
(name of participant)
TPAPN to use and disclose my PHI for purposes other than treatment, payment, or health care operations. I specifically authorize TPAPN or TPAPN designated employee(s) to disclose my PHI, as identified below, to the academic program listed ("PROGRAM"):

Nursing Academic Program:_____**Phone:**_____
(name of program)

Address_____**City:**_____**State**:_____**Zip**:_____
(address of program)

I understand that by signing this authorization, TPAPN and PROGRAM may communicate with each other and exchange all information (including information obtained from third-parties) relating to my participation in TPAPN and my enrollment in the PROGRAM including, but not limited to, my:

- Status in TPAPN including nonadherence, e.g., withdrawal or dismissal;
- Return to academics (clinical and classroom) accommodations;
- Academic performance;
- Ability to practice nursing;
- My inability to remain abstinent from all abusable substances.

I understand that TPAPN typically communicates with the immediate dean or director of PROGRAM and faculty, and nurses at the clinical site who oversee my clinical activities as I progress through the academic program, if I am nonadherent.

I authorize TPAPN and PROGRAM to disclose my PHI electronically.

I understand that my record may include information about my diagnosis and treatment for substance use disorder and/or psychiatric disorder, and other sensitive information that is protected by federal and/or state law.

I understand that federal law generally prohibits re-disclosure of substance abuse treatment without my consent.

RE-DISCLOSURE OF INFORMATION:

I understand that there is a potential for information disclosed pursuant to this authorization to a non-health care entity to be subject to re-disclosure by the recipient and no longer be protected by state or federal privacy regulations.

I further understand that by disclosing information to PROGRAM, PROGRAM may disclose my information to faculty members and nurses at the clinical site who have a legitimate need to know and authorize such disclosures.

I release TPAPN/MHSP/EEP from any liability for such re-disclosure(s).

PURPOSE OF DISCLOSURE:

TPAPN will use and disclose my PHI with PROGRAM in order to facilitate:

- Participation in TPAPN,
- Recovery from any problems I may be experiencing with psychiatric or other behavioral disorder or medical condition and
- My ability to continue or return to nursing academics/practice in a manner that is conducive to safe patient care.

(Form continues on next page)

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Print Name_____/case#_____

CONSENT TO DISCLOSE INFORMATION BETWEEN TPAPN AND ACADEMIC PROGRAM

REVOCATION:

I understand that I can revoke this Authorization in writing at any time except to the extent that action has been taken in reliance on it.

I understand TPAPN is relying on this Authorization in permitting me to participate in TPAPN and may disclose the information covered by this Authorization even if I revoke this Authorization. In the event I withdraw or am dismissed from TPAPN, TPAPN may notify PROGRAM that I have withdrawn or been dismissed even if I revoke this Authorization and that PROGRAM likewise may notify TPAPN if I am performing unsatisfactorily in, have been dismissed or leave the academic program even if I revoke this Authorization. I specifically authorize such disclosures even after my revocation of this Authorization.

I understand that I may revoke this Authorization only in a signed, written revocation provided via certified U.S. mail addressed to TPAPN c/o Texas Nurses Foundation, 4807 Spicewood Springs Rd., Bldg. 3, Suite 100, Austin, TX 78759 or facsimile addressed to TPAPN at 512-467-2620 or such other address or facsimile TPAPN instructs me to use. The written revocation must include the following information:

- My name and address, TPAPN case number, and Texas nursing license number;
- PROGRAM name and address as set out above;
- Date I signed this Authorization as set out below; and
- My intent to revoke this authorization.

Unless a later date is specified in the revocation, the revocation will be effective at the close of the next business day following receipt by TPAPN.

If not previously revoked, this authorization will terminate 60 days after I complete, withdraw or am dismissed from TPAPN.

ACKNOWLEDGEMENT

I have read this authorization and understand what information will be used or disclosed or re-disclosed, who may use, and re-disclose the information, the recipient(s) of that information, and the circumstances in which my PHI will be disclosed/re-disclosed even after my written revocation.

Participant's Printed Name:_____

Participant's Signature:_____

Date:_____ **Case Number:**_____