TEXAS PEER ASSISTANCE PROGRAM FOR NURSES

Print Name____/case#__________________

CONSENT TO DISCLOSE INFORMATION TO LICENSING BOARDS

I understand a condition of my participation in the Texas Peer Assistance Program for Nurses ("TPAPN") is that I authorize TPAPN to use and disclose my Protected Health Information ("PHI") to the Texas Board of Nursing ("BON") and any other state or federal agency that has issued me a license to provide patient care. I further understand that if I am issued licenses in addition to those I current hold, that 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's designated employee(s) to disclose my PHI, including my entire TPAPN record except for treatment records to the BON and the following recipient(s) (collectively "BON/BOARDS"):

Name: ____

(list any state or federal agency other than BON which has issued you a license to provide patient care)

I understand that by signing this authorization, TPAPN and BON/BOARDS may communicate with each other and exchange all information (including information obtained from third-parties except treatment records) relating to my participation in TPAPN, including, but not limited to:

- Any information provided to TPAPN by the third party at the time of referral or any information relating to my practice prior to my referral;
- The results of any assessment, evaluation or diagnosis performed or used for the purpose of determining my eligibility or continued eligibility for TPAPN;
- The dates of my participation in TPAPN;
- My status in the program including any violations of the terms of participation and the reason for my dismissal or withdrawal;
- Any professional judgments/conclusions (with supporting documentation) of health care providers that I am unable to practice nursing safely or that my practicing nursing would jeopardize patient care;
- The results of any drug tests;
- Any information that TPAPN, in its sole discretion, determines is evidence that I have exposed or am likely to expose patients or others unnecessarily to a risk of harm; and
- Prior participation in TPAPN.

I authorize TPAPN and BON/BOARDS 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 understand BON/BOARDS may re-disclose any information obtained under this Authorization to the same extent they disclose information relating to a complaint against a licensee.

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

PURPOSE OF DISCLOSURE:

TPAPN will use and disclose my PHI with BON/BOARDS for the purpose of a) ensuring I do not engage in nursing practice if I am unfit to practice or that may be inconsistent with safe patient care and b) determining if BON/BOARDS should take any action against my nursing license or other license to provide patient care.

The disclosure of my entire record except for treatment records is necessary in order to accomplish these purposes.

(Form continues on next page)

Print Name____/case#__________________

CONSENT TO DISCLOSE INFORMATION TO LICENSING BOARDS

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 the TPAPN program and may disclose the information covered by this Authorization even after I revoke this Authorization.

For individuals who were referred by 3rd-parties, and individuals who self-referred but were also referred by a 3rd party:
I further understand that TPAPN, even if I revoke this Authorization, will report my final status in the program to BON/BOARDS including election not to participate, withdrawal, failure to successfully complete, dismissal for nonadherence (including failure to abide by restrictions imposed on my practice), and if board-ordered to TPAPN, my successful completion.

For individuals who self-referred to TPAPN:
In the event I do not successfully complete the program, I understand that TPAPN, even if I revoke this Authorization, will report my final status in the program to BON/BOARDS including withdrawal or dismissal for nonadherence and/or failure to abide by restrictions imposed on my practice.

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 TPAPN 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;
- BON/BOARDS 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 the later of 60 days after I successfully complete TPAPN or 60 days after final disposition by BON/BOARDS of any investigation of my practice including any appeals.

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:**_________________________

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS: Substance use disorder information disclosed by TPAPN pursuant to this Authorization is required by federal law to include the following notice:

> **This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.**