TEXAS PEER ASSISTANCE PROGRAM FOR NURSES

Print Name_____/case#_____

CONSENT TO DISCLOSE INFORMATION TO FAMILY MEMBERS / SIGNIFICANT OTHERS / EMERGENCY CONTACT

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 an emergency contact. I further understand that if I wish to add a contact, 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, to my emergency contact(s) listed below (CONTACT(S):

Name: _____ **Relationship:**_____
(name of emergency contact)

Address_____ **City:**_____ **State**:_____ **Zip**:_____

Phone: (Home) _____ **(Work)** _____ **(Cell)** _____ **(Best # To Call):** _____

I understand that by signing this authorization, TPAPN and CONTACT(S) may communicate with each other and exchange all information (including information obtained from third-parties) relating to my participation in TPAPN and any problems I am experiencing with substance use disorder and/or psychiatric disorders.

I authorize to TPAPN and CONTACT(S) 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 CONTACT(S), CONTACT(S) may disclose my information to healthcare providers, emergency personnel and law enforcement.

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

PURPOSE OF DISCLOSURE:

TPAPN will use and disclose my PHI with CONTACT(S) in order to facilitate a timely and appropriate response in the event of an emergency such as a medical emergency or there is concern I have exposed myself or others, or am likely to expose myself or others, to a risk of harm.

The disclosure of my entire record is necessary in order to accomplish these purposes.

(Form continues on next page)

CONSENT TO DISCLOSE INFORMATION TO FAMILY MEMBERS / SIGNIFICANT OTHERS / EMERGENCY CONTACT

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 program and may disclose the information covered by this Authorization even if I revoke this Authorization. In the event of an emergency, TPAPN may notify CONTACT(S) of that emergency, my participation, and any problems I am experiencing with substance use disorder and/or psychiatric disorders in TPAPN even if I revoke this Authorization and that CONTACT(S) likewise may notify TPAPN in the event of an emergency 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 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;
- CONTACT(S) 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:**_____

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. A 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.