TEXAS PEER ASSISTANCE PROGRAM FOR NURSES

Print Name_____/case#_____

CONSENT TO DISCLOSE INFORMATION GENERAL

Under federal law an authorization for the Texas Peer Assistance Program for Nurses, hereafter referred to as "TPAPN," to release information to an individual or entity at the request of the participant must meet certain requirements. A general consent for release of medical information is not sufficient. To avoid delay, TPAPN strongly recommends this form be used.

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, as identified below, to ("RECIPIENT"):

Name: _____ **Phone:**_____
(name of specific person or organization to which disclosure is to be made)

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

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

- ☐ Drug Screens
- ☐ Meeting Attendance (12 Step Meetings)
- ☐ Treatment Recommendations
- ☐ Drug Abuse Treatment
- ☐ Alcohol Treatment
- ☐ Hepatitis B or C Testing
- ☐ HIV/Acquired Immune Deficiency Syndrome (AIDS)
- ☐ Mental/Behavioral Health and Developmental Disability Treatment
- ☐ Support Group
- ☐ Work Agreement
- ☐ Other

If Other (please specify) _____

☐ Entire Record not including treatment records. Must state why entire record is needed to be disclosed:

_____

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

PURPOSE OF DISCLOSURE:

TPAPN will use and disclose my PHI with RECIPIENT for the following purpose:

- ☐ Probation
- ☐ Other Peer Assistance Alternative Program
- ☐ Attorney
- ☐ Other

If Other (please specify) _____

(Form continues on next page)

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Print Name_____/case#_____

CONSENT TO DISCLOSE INFORMATION GENERAL

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 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;
- RECIPIENT'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.