TEXAS PEER ASSISTANCE PROGRAM FOR NURSES

Print Name_____/case#_____

CONSENT TO DISCLOSE INFORMATION BETWEEN TPAPN AND HEALTHCARE PROVIDER

NOTE: This authorization/consent form ("Authorization") is to be used only for exchange of information between TPAPN and healthcare providers.

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 my health care providers. I further understand that if I add or change providers, 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, as identified below, to following health care provider ("PROVIDER"):

Name of Facility:_____

Phone:_____

Address of Facility:_____ **City:**_____ **State**:_____ **Zip**:_____

Type of Healthcare Provider: **Check only one:**

☐ **Addiction Specialist** ☐ **Psychiatrist** ☐ **Therapist/Counselor** ☐ **Primary Care Physician** ☐ **Dentist**

☐ **Other**_____

I understand that by signing this authorization, TPAPN and PROVIDER may communicate with each other and exchange information (including information obtained from third-parties) relating to my participation in TPAPN and any assessment or treatment I am receiving, have received or will receive including, but not limited to:

- My status in TPAPN including my nonadherence, withdrawal or dismissal;
- Any problems I may be experiencing with substance use disorder and/or psychiatric disorder;
- Any assessment, diagnostic, treatment, rehabilitation or aftercare services I am receiving or have received; and
- My work performance and ability to practice nursing.

I authorize TPAPN and PROVIDER 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).

(Form continues on next page)

CONSENT TO DISCLOSE INFORMATION BETWEEN TPAPN AND HEALTHCARE PROVIDER

PURPOSE OF DISCLOSURE:

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

- Participation in TPAPN,
- Recovery from any problems I may be experiencing with substance use disorder and/or psychiatric disorder, and
- Return to nursing practice in a manner that is conducive to both my recovery and safe patient care.

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. In the event I withdraw or am dismissed from the program, TPAPN may notify PROVIDER that I have withdrawn or been dismissed from the program even if I revoke this Authorization and that PROVIDER likewise may share information about my assessment or treatment or notify TPAPN if I leave treatment 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;
- PROVIDER'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.