Consent to Release, Use and Exchange of Information

Addendum to Consent #1

Licensee: _____ Date of Birth: _____

I, _____, authorize Uprise Health, also known as Health Professionals' Services Program ("Program"), to obtain, release, use and exchange my confidential health treatment information including, but not limited to, my use of prescription medication or use of impairing or mood altering substances or medications with addictive potential, my drug, alcohol and mental health treatment records from the Program and/or the status of my participation in the Program to the persons or entities identified in all prior Consent to Release, Use and Exchange of Information forms previously signed by me, including the individual or entity named below [re-release between the below listed individual or entity is not authorized in accordance with 42CFR Part 2 and ORS 676.190-676.200]:

_____

*(The **name** of the person or entity **must be** provided)*

The information to be released, used, exchanged and/or disclosed is: [*Each item must be initialed*]

____ Alcohol, Drug or Mental Health Evaluations/Assessments

_____ Progress notes

_____ Treatment plan(s)

_____ Discharge summary

_____ Summary of Services Rendered

_____ Attendance reports

_____ Prescription medications including medications with addictive, mood altering and/or impairing potential

_____ Drug testing collection site reports

_____ Drug testing laboratory reports

_____Medical Records

_____ Employer Information

_____ Board referral information ***(DO NOT INITIAL IF SELF REFERRED)***

_____ Collateral reports

_____ Compliance with Monitoring Agreement

_____ Other: ____N/A_____

The disclosures authorized in this consent are to: monitor, coordinate and ensure compliance with the Program and ORS 676.190 - 676.200.

I understand that my alcohol and/or drug treatment and mental health records are protected under federal and state laws and regulations (42 CFR Part 2, ORS 430.399(5) and ORS 179.505) governing confidentiality of alcohol and drug abuse patient records and protect health information records generally and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke my consent to release such records at any time except to the extent that prior action has been taken in reliance upon it. I understand that for my revocation of consent to be effective, it must be in writing. In the event I am a self-referred participant for substance abuse in the Program and I revoke my Consent to Release, Use and Exchange of Information form(s), I understand that the Program is required by Oregon Administrative Rule 415-065-0055 to seek a court order authorizing release of alcohol or drug information protected under 42 CFR Part 2 and ORS 179.505. If I am a Board referred participant in the Program due to my abuse of any substance(s) (drugs or alcohol) and I revoke my Consent to Release, Use and Exchange of Information form, the Program is compelled by ORS 676.190 to remove my name from the list of enrollees who are participating in the Program, which list will be provided to my licensing Board and my licensing Board will know of my non-participation in the Program. If I am either a self or Board referred participant in the Program due to a diagnosis of mental health disorder and I revoke my Consent to Release, Use and Exchange of Information form, the Program will report such revocation to my licensing Board.

I authorize the disclosure, use and re-release by the Program of my alcohol, drug and/or mental health treatment records, which records are protected as noted above. I further authorize the Program to release any other protected health information which it has received pursuant to a valid release of medical information form which I have signed.

I understand if I report abuse of a child or an elder or that I intend to harm myself or others, my confidentiality will be broken, and action will be taken in accordance with federal and state laws and regulations.

If not previously revoked, this Consent will automatically expire the later of one year from the date of signing or my successful completion of or termination from the Program.

Full Legal Signature of Licensee *OR* Licensee's Authorized Representative	Relationship to Licensee	Date

Health Professionals' Services Program
PO Box 8668, Portland OR 97207
Phone: 888.802.2843 / Fax: 503.961.7142
hpsp@uprisehealth.com
www.hpspmonitoring.com