

## Consent to Release, Use, and Exchange of Information (#1)

1. Licensee Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

2. I, \_\_\_\_\_, **authorize** Integrated Behavioral Health, aka 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 below [re-release between the below listed individuals or entities is not authorized in accordance with 42 CFR Part 2 and ORS 676.190-676.200]:

[Complete and **initial all lines that pertain to you - mandatory per ORS 676.190-676.200 and OAR Chapter 415-065, et. sec.**] **See cover letter for line by line instructions**

3. \_\_\_\_\_  
Initial (Monitoring Entity **name** and **address** if outside the State of Oregon)

4. \_\_\_\_\_  
Initial (Your Independent **Third Party Evaluator** – The Third Party Evaluation is the Mental Health/Chemical Dependency Assessment completed to determine eligibility to the HPSP program.)

5. Paul Dueber, Dueber Associates  
Initial (Entity Performing Fitness for Safe Practice Investigation/Evaluation – **FOR SELF REFERRALS**)

6. \_\_\_\_\_  
Initial (Your Licensing Board) - **Only Board Referred licensees must initial this line. Self-referred licensees should not initial this line**

7. Medtox Diagnostics, St. Paul, MN  
Initial (Drug Testing Facility **name** and **address**) the only information to be released to Medtox is licensee name, drug panel, and testing schedule.

8. Omega Laboratories, Inc., Mogadore, OH  
Initial (Split sample testing) the only information to be released to Omega is licensee name, drug panel, and testing schedule.

9. United States Drug Testing Laboratories, Inc. (USDTL), Des Plaines, IL  
Initial (Hair collection testing) the only information to be released to USDTL is licensee name, drug panel, and testing schedule.

10. MROExpress, Ft. Lauderdale, FL  
Initial (Medical Review Officer)

11. \_\_\_\_\_  
Initial (Treatment Provider **name** and **address**)

12. \_\_\_\_\_  
Initial (Treatment Provider **name** and **address**)

13. \_\_\_\_\_  
Initial (Treatment Provider **name** and **address**)

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

- |   |  |
|---|--|
| _____ Alcohol, Drug, or Mental Health evaluation/assessment   | _____ Drug testing collection site reports |
| _____ Progress notes  | _____ Drug testing laboratory reports      |
| _____ Treatment plan(s)   | _____ Medical Records                      |
| _____ Discharge summary   | _____ Employer Information                 |
| _____ Summary of Services Rendered  | _____ Board referral information           |
| _____ Attendance reports  | _____ Collateral reports                   |
| _____ Prescription medications including medications with addictive, mood altering and/or impairing potential | _____ Compliance with Monitoring Agreement |
|   | _____ Other: _____                         |

**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 and ORS 676.195 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 Board will know of my non-participation. 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 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.

**DO NOT RETURN THIS CONSENT INCOMPLETE – PLEASE CALL WITH ANY QUESTIONS**

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

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulation (42 CFR, Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. 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 the patient.  
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