WASHINGTON PHYSICIANS HEALTH PROGRAM

CONSENT FOR DISCLOSURE

Name:_____ Date of Birth:_____

I authorize the Washington Physicians Health Program (WPHP) to release and obtain information (including written, verbal, and/or electronic reports) to/from the following entity or individual(s):

I. Individual or Organization: _____

Individual participants of Organization:
_____
_____
_____

II. Amount and Kind of Information:

Check	Description
☐	**Referral Disclosure**: behavioral observations, disciplinary issues, staff/patient complaints, work performance concerns, status and results of evaluation process, recommendations
☐	**General Compliance Disclosure:** behavioral observations, dates of service, modes of monitoring, fitness for duty, compliance with monitoring, level of cooperation with WPHP, discharge information
☐	**Full Clinical Disclosure:** diagnoses, treatment plans, progress in treatment, program compliance, findings from outside evaluations, labs, medications, fitness for duty, treatment/discharge recommendations
☐	**Key Support Disclosure:** Orientation to WPHP, overview of recovery and family/friend roles and needs.
☑	**Substance use disorder information:** ☑ ALL ☐ Medications ☐ Diagnoses ☐ Test Results ☐ Treatment Recommendations ☐ Other (please specify) _____
☐	**Other** (please specify): _____

III. Exclusions (if any):

Check	Description
☐	Please exclude the following information from the disclosure(s) above:_____

IV. The purpose of the disclosure or release:

☐ Employment/Education Continuation ☐ Licensing/Credentialing ☐ Evaluation and/or treatment ☐ Insurance
☐ Coordination of health care ☐ Financial ☐ Legal
☐ Family/Friend Support ☐ Other (please specify):_____

- I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire one year from date of case resolution or discharge from WPHP.
- I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.
- I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

Signature: _____ Date:_____