RELEASE OF INFORMATION

☐ **NON-REGULATORY MONITORING** ☐ **REGULATORY MONITORING**

I, _____, *(Licensee/Patient/Client/Representative's Name)*
hereby authorize the Health Professional Recovery Program (HPRP) to release, exchange, or obtain information contained in the records of HPRP treatment service provider(s) and worksite monitors for:

_____	___ / ___ / ____	_____
Licensee/Patient/Client's Name	*Date of Birth*	*Case Number*

to _____
Name of individual to whom information is to be released

to monitor compliance with the HPRP as further described below:

- Types of information to be disclosed may include: Psycho-Social History/Evaluation, Psychiatric Evaluation, Psychological Test Reports, Treatment Summaries, Medical Records, Educational Reports, Discharge Information, Lab Reports Progress Notes and other information deemed appropriate to monitor my compliance with program requirements.
- This would include, if applicable, information about serious communicable diseases and infections as defined by Michigan Department of Licensing and Regulatory Affairs (which includes AIDS, AIDS-related Complex and HIV infection, Tuberculosis, Hepatitis B, Hepatitis C, Venereal Disease); and alcohol and drug abuse records otherwise protected from disclosure under state or federal law.
- The purpose of disclosure is for the HPRP to use the information and records disclosed to determine my status in the Program. I understand that the HPRP may further disclose the information and records to the Michigan Department of Licensing and Regulatory Affairs (LARA) if warranted or required by MCL §§ 333.16168; 333.16169; and/or, 333.16170. I further understand that the Michigan Department of Licensing and Regulatory Affairs (LARA) and/or the Department of Attorney General may use the information and records disclosed to administer and enforce the laws of Michigan, including but not limited to M.C.L. §§ 333.16211; 333.16221; and, 333.16231. The HPRP may not release the information and records for any other purpose than those purposes allowed under Article 15 of the Michigan Public Health Code, MCL 333.16010 et.seq.
- By sending a written revocation, I may revoke this authorization at any time, except to the extent that action has already been taken in reliance on this authorization. Unless expressly revoked earlier, this authorization expires four (4) years from the date of the participant's signature below, or upon participant's successful completion in the program and notification by the HPRP Contractor of such completion to the party identified in this authorization, whichever occurs first.
- Applicable Law: This information is released subject to the provisions of the Michigan Public Health Code, the Michigan Mental Health Code, and federal confidentiality rules.

_____	___ / ___ / ___
Participant's Signature	*Date Signed*
_____	___ / ___ / ___
Witness Signature	*Date Signed*

WITNESS SIGNATURE IS A REQUIREMENT TO BE VALID

P.O. Box 842 · Troy, Michigan 48099-0842 · (800) 453-3784 · Fax: (248) 519-0373