STEP 2 - HPRC REVIEW OF HPRP CLINICAL TEAM STEP 1 DECISION

LICENSEE MUST SEND COMPLETED DOCUMENTATION TO: HPRP CONTRACT COORDINATOR, 611 W. OTTAWA ST. P.O. BOX 30670, LANSING, MI 48909. Questions may be directed to (517) 241-5610 or BPL-HPRP@michigan.gov.

Date: ___________________

Licensee Name:______________________________Case Number:______________________

Phone Number:___________________________ Case Manager:_____________________

My Step 1 request to change the HPRP's Clinical Team decision in their internal review process was:

☐ Denied

☐ Partially denied

*Please refer to the internal review documents you will receive from the HPRP Clinical Team for their rationale.

☐ **I am requesting an HPRC Review of the HPRP Clinical Team Step 1 decision and requesting the HPRC change the Clinical Team's Step 1 decision only. No additional/different request will be added to this document.**

I believe the Step 1 decision should be changed because:

☐ I have attached additional documentation to support my request that was not available to the Clinical Team when their Step 1 decision was made.

☐ I have attached new documentation from my HPRP Provider that was not available to the Clinical Team when their Step 1 decision was made.

____ ____________________

Licensee Signature Date

STEP 2 – HPRC REVIEW OF HPRP CLINICAL TEAM STEP 1 DECISION / PROVIDER INPUT

TO BE COMPLETED BY TREATMENT PROVIDER

Licensee Name: ____

Provider Name:____

Relationship to licensee: ☐ Addictionist ☐ Psychiatrist ☐ Pain Specialist ☐ Therapist

Opinion of request:

☐ I support the request.

☐ I do not support the request.

☐ I support the licensees right to request a Step 2 Review.

Comments:

____ _____________________

HPRP Treatment Provider Signature Date

AUTHORIZATION FOR

RELEASE OF PRIVILEGED INFORMATION

TO MICHIGAN HEALTH PROFESSIONAL RECOVERY SUBCOMMITTEE

I,____

(HPRP Participant's Name)

hereby authorize the Health Professional Recovery Program (HPRP) to release/exchange to the Health Professional Recovery Committee and the State of Michigan HPRP Contract Administrator information contained in my records.

(Please print name)	*(Indicate any previous name)*
Date of Birth	Case *Number*

Under the conditions described below:

1. **TYPE OF INFORMATION TO BE RELEASED:** Information contained in the files of the HPRP contractor (Health Professional Recovery Program) including but not limited to: Medical Records, Patient Progress Notes, Discharge Information, Treatment Summaries, Psycho-Social History/Evaluations, Substance Abuse/Chemical Dependence Evaluations, Psychiatric Evaluation, Psychological Test Reports, Pain Management Evaluations, Lab Reports, Educational Reports, Correspondence/Memoranda, signed or proposed Monitoring Agreements, Case Conference Reviews and Progress Notes.

   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) if any; alcohol and drug abuse records are protected under Code 41 of the Federal Regulations, Part II.

2. **PURPOSE OF DISCLOSURE:** The information described above is being released to: (1) the administrator of the Health Professional Recovery Committee (HPRC) in the Bureau of Health Professions, Department of Licensing and Regulatory Affairs to facilitate the review of the "Review" and (2) to the members of the Health Professional Recovery Committee and or "Review" subcommittee for the purpose of considering a "Review" to a decision of the HPRP contractor (Health Professional Recovery Program).

3. **REVOCATION OR EXPIRATION OF AUTHORIZATION:** The disclosure of the information and records described above will expire with the decision of the Health Professional Recovery Committee and the communication of the decision.

4. **APPLICABLE LAW:** The information is released subject to the provisions of the Michigan Mental Health Code, and Federal PA258, as amended and Federal Confidentiality Rules (43 CFR, Part 2).

HPRP Participant's Signature	*Date Signed*
Witness Signature	*Date Signed*