



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

LICENSEE MUST SEND COMPLETED DOCUMENTATION TO THE HPRP CONTRACT ADMINISTRATOR

Mail: 611 W. OTTAWA ST., P.O. BOX 30670, LANSING, MI 48909.

Email: [BPL-HPRP@michigan.gov](mailto:BPL-HPRP@michigan.gov)

Fax: (517) 241-7535.

Questions may be directed to (517) 241-5610 or by any of the above-listed methods.

Date: \_\_\_\_\_

Licensee Name: \_\_\_\_\_ Case Number: \_\_\_\_\_

Licensee Mailing Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Case Manager: \_\_\_\_\_

**My 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 decision of Step 1 decision only. No additional/different request will be added on this document**

I believe this decision should be changed because:

- Additional documents included.
- I have attached new documentation from my HPRP Provider(s).

\_\_\_\_\_  
Licensee Signature

\_\_\_\_\_  
Date

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



## 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 licensee's right to request a Step 2 Review.

### **Comments:**

\_\_\_\_\_  
HPRP Treatment Provider Signature

\_\_\_\_\_  
Date

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**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 PA 258, as amended and Federal Confidentiality Rules (43 CFR, Part 2).

\_\_\_\_\_  
*HPRP Participant's Signature*

\_\_\_\_\_  
*Date Signed*

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