Consent to Release Confidential Information

Practitioner Name: _____

Date of Birth: _____ Social Security Number: _____

Telephone Number: _____

License Number(s): _____ Profession: _____

I hereby authorize Professionals Resource Network, Inc. ("PRN") to release the information indicated below to:

Name **(Individual and Entity)**, If applicable: _____

_____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone number: _____ Email: _____

This Consent includes the following information (each authorized disclosure must be initialed by the Practitioner):

____ ALL Records and Information (of any kind and in any format)
____ Oral statements and/or testimony by PRN personnel (without limitation)
____ Participant Contract
____ Participant Manual
____ PRN Correspondence (copies of correspondence sent by PRN to the Practitioner)
____ Drug/Alcohol Screen Results (including date; negative/positive; and if positive, the substance(s) for which the screen was positive)
____ Publicly-Available Department of Health and Licensure Board Documents (relating to administrative proceedings involving the Practitioner)
____ Department of Health Voluntary Agreement to Withdraw From Practice ("VWP") Completed by the Practitioner
____ Rescission of VWP Completed by the Practitioner
____ Consent Forms Previously Signed by the Practitioner
____ Compliance Letters (correspondence by PRN stating the Participant is compliant with the program)
____ Correspondence from PRN to the Participant's Treatment Providers
____ Other, Described as Follows: _____

I understand that this Consent authorizes the release of information that may otherwise be confidential under Florida and/or federal law, including 42 C.F.R. Part 2. This Consent is for the specific purpose of:

_____.

I understand that I may revoke this Consent at any time except to the extent that PRN has already acted in reliance on it. I hereby release PRN, its employees, and agents from any liability which may arise as a result of any disclosure made pursuant to this Consent. A copy of this Consent is as valid as the original.

Unless earlier revoked, this Consent will expire (to be initialed by Practitioner):

____ One year from the date signed; or
____ One year from the date of my successful completion of the impaired practitioner program operated by PRN; or
____ On the following date, event, or condition (specify): _____

_____ _____

Practitioner's Signature Date

Return to: PRN, P.O. Box 16510, Fernandina Beach, FL 32035-3126.