

**Consent to Release Confidential Information**

Practitioner Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
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 (including Participant Manual)
- \_\_\_\_ PRN Correspondence (copies of correspondence sent by PRN to the Practitioner)
- \_\_\_\_ Drug/Alcohol Screen Results
- \_\_\_\_ Publicly-Available Department of Health ("DOH") and Licensure Board Documents (relating to administrative proceedings involving the Practitioner)
- \_\_\_\_ DOH 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: \_\_\_\_\_

This Consent does not authorize, and cannot be used for, the release of substance use disorder counseling notes. To consent to the release of substance use disorder counseling notes, PRN's separate Consent to Release Confidential Substance Use Disorder Counseling Notes must be used.

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: \_\_\_\_\_

If the recipient is a HIPAA covered entity or business associate to whom records are disclosed for purposes of treatment, payment, or health care operations, the records may be redisclosed in accordance with the HIPAA regulations, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings.

I understand that I may revoke this Consent in writing to PRN 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.