Consent to Release, Use and Exchange of Information (#2)
[Self-Referred]

Licensee Name: _____ Date of Birth: _____

I, _____, authorize Integrated Behavioral Health, aka Health Professionals' Services Program ("Program"), to obtain, release, use and exchange my confidential health treatment information including, but not limited to, **my use of prescription medication or use of impairing or mood altering substances or medications with addictive potential**, my drug, alcohol and mental health treatment records from the Program and/or the status of my participation in the Program to the persons or entities identified below [re-release between the below listed individuals or entities is not authorized in accordance with 42 CFR Part 2 and ORS 676.190-676.200]:

[*Each line must be **initialed** - mandatory per ORS 676.190-676.200 and OAR Chapter 415-065, et. seq.*]

_____ _____
Initial (Monitoring Entity **name** and **address** if outside the State of Oregon)

_____ _____
Initial (Employer **name** and **address** – when employed)

_____ _____
Initial (Monitoring Entity **name** and **address** if outside the State of Oregon)

_____ _____
Initial (**Licensing Board** – as authorized by ORS 676.190-676.200 and OAR 415-065-0060(2))

The information to be released, used and/or exchanged is any information which I have expressly agreed to the release thereof including, but not limited to:

- My engaging in criminal behavior;
- My engaging in conduct that could cause injury, death or harm to the public, including engaging in sexual impropriety with a patient;
- My practicing while impaired in a health care setting in the course of my employment;
- My receiving a positive toxicology test result as determined by federal regulations pertaining to drug testing;
- My being admitted to the hospital for mental illness or adjudged to be mentally incompetent;
- My entering into a Provisional Monitoring Agreement, a Monitoring Agreement, a Provisional Enrollment Agreement or an Enrollment Agreement and thereafter failing to participate in the Program
- My failure to enter into an Amended Monitoring Agreement if requested by the Program;
- My refusal to sign any amended form deemed necessary by the Program; or
- Any other conduct which the Program, in its sole discretion, considers to be in substantial noncompliance with any agreement I have signed as between myself and the Program
- My failure to comply with the Nurse Practice Act prior to my enrollment in the Program.

Any report to my licensing Board by the Program shall include the following information:

IBH Health Professionals' Services Program
1220 SW Morrison St. #600
Portland, Oregon 97202-2126
1.888.802.2843
Fax: 503-961-7142
hpspmonitoring.com

- The date and description of the noncompliance;
- A copy of the report from the independent third party who diagnosed my alcohol, drug and/or mental health condition, which report shall set forth my diagnosis;
- A copy of my then current Monitoring Agreement; and
- A statement of my employment status

The disclosures authorized in this consent are to: monitor, coordinate and ensure compliance with the Program and ORS 676.190 – 676.200.

I understand that my alcohol and/or drug treatment records are protected under federal and state laws and regulations (42 CFR Part 2, ORS 430.399(5) and ORS 179.505) governing confidentiality of alcohol and drug abuse patient records and protect health information records generally, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke my consent to release such records at any time except to the extent that prior action has been taken in reliance upon it. I understand that for my revocation of consent to be effective, it must be in writing. In the event my participation in the Program was due to my abuse of any substance(s) (drugs or alcohol), if I revoke my Consent to Release, Use and Exchange of Information form(s), I understand that the Program is required by Oregon Administrative Rule 415-065-0055 to seek a court order authorizing release of alcohol, drug or mental health information protected under 42 CFR Part 2 and ORS 179.505.

If my enrollment in the Program was due to a diagnosis of a mental health disorder, I agree that if I revoke my Consent to Release, Use and Exchange of Information form which, among other things, allows disclosure of my mental health treatment records, or if I revoke my Authorization to Use and Disclose Protected Health Information - including mental health treatment records, such act(s) will constitute my voluntary disenrollment from the Program. I understand that under such circumstances, the Program is compelled by ORS 676.190 and associated Administrative Rules to report my disenrollment to my licensing Board and the licensing Board will know of my disenrollment.

I authorize the disclosure, use and re-release by the Program of my alcohol, drug and/or mental health treatment records, which records are protected as noted above and the information regarding my participation or lack of participation in the Program as required by ORS 676.190-676.200 and OAR Chapter 415-065, et. seq. I further authorize the Program to release any other protected health information which it has received pursuant to a valid release of medical information form which I have signed.

I understand if I report abuse of a child or an elder or that I intend to harm myself or others, my confidentiality will be broken and action will be taken in accordance with federal and state laws and regulations.

If not previously revoked, this Consent will automatically expire the later of one year from the date of signing or my successful completion of the Program.

Full Legal Signature of Individual OR Authorized Personal Representative	Relationship to Licensee	Date

IBH Health Professionals' Services Program
1220 SW Morrison St. #600
Portland, Oregon 97202-2126
1.888.802.2843
Fax: 503-961-7142
hpspmonitoring.com