

# Consent to Services Enrollment Agreement

## [Board Referred]

I, \_\_\_\_\_, am a licensee of the \_\_\_\_\_ (“Board”). I acknowledge that I have been referred to Reliant Behavioral Health, LLC, aka Health Professionals’ Services Program (“Program”) by my Board and previous to such referral, I have been diagnosed by a Board-approved third party evaluator as having a:

[initial appropriate line]

- \_\_\_\_\_ substance use disorder
- \_\_\_\_\_ mental health disorder
- \_\_\_\_\_ substance use and mental health disorders

I understand that the Program is not permitted to diagnose or treat a licensee. The Program is the non-treatment compliance monitor that the Oregon Health Authority contracts with to track and report a licensee’s compliance with the monitoring program for health professionals as set forth in ORS 676.190 through ORS 676.200 and specifically my compliance with my Monitoring Agreement. All diagnosis and treatment of licensees shall be done by or through third parties. I consent to the services of the Program and understand that the following terms and conditions apply throughout the term of my participating in the Program:

1. **I agree to:**
  - a. sign all written authorizations/consents necessary to allow the Program to disclose and exchange information regarding my diagnosis, physical or mental health, use of mind-altering or intoxicating substances or potentially addictive drugs, unless the Program has previously approved use of a particular drug prescribed for me by a person authorized by law to prescribe the drug for a documented medical condition.
  - b. report to the Program:
    - i. my use of any mind altering or intoxicating substances potentially addictive drugs within twenty-four hours of use; or
    - ii. any professional practice on my part that does not comply with limits set by my Board or the Program.
  - c. participate in my treatment plan as outlined by a Board-approved third party evaluator and as approved by the Program. I understand that the treatment plan may include treatment for any disorder that I may have, including but not limited to gambling and eating disorders.

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulation (42 CFR, Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute the patient.

**I acknowledge:**

- d. the Program shall report my testing positive on any toxicology tests required by the Program or my failure to participate in Program required toxicology testing to my licensing board.
  - e. the Program may report my failure to report at least weekly to the Program, my compliance with the terms of my Monitoring Agreement and any addenda thereto.
  - f. the Program may report my failure to attend compliance consultation group meetings if so required by the Program.
2. I agree that the Program may contact my Board from time to time regarding my participation in the Program and may exchange any information with my Board which the Program, in its sole judgment, deems necessary and appropriate.
  3. I agree that the Program may, in its reasonable and sole judgment, request that I immediately cease my practice and understand that if I should fail or refuse to do so, the Program will report such failure or refusal to my licensing Board pursuant to ORS 676.190.
  4. I understand and agree that any of the following acts on my part must be reported to my licensing Board by the Program within one business day of the Program's being made aware of such noncompliance:
    - a. my engaging in criminal behavior;
    - b. my engaging in conduct that could cause injury, death or harm to the public, including engaging in sexual impropriety with a patient;
    - c. my practicing while impaired in a health care setting in the course of my employment;
    - d. my receiving a positive toxicology test result as determined by federal regulations pertaining to drug testing;
    - e. my violating a restriction on my practice imposed by the Program or my Board;
    - f. civil commitment for mental illness;
    - g. my entering into a Monitoring or Consent to Services Enrollment Agreement, but failing to participate in the Program;
    - h. my failure to enroll in the Program after being referred by my Board; or
    - i. any other conduct which the Program, in its sole discretion, considers to be in substantial noncompliance with my Monitoring Agreement and any addenda thereto.

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

- i. the date and description of the noncompliance;

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- ii. 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;
  - iii. a copy of my then current Monitoring Agreement and any addenda thereto; and
  - iv. a statement of my employment status.
5. I understand and agree that based on the report by the Program, my Board may take action to suspend, restrict, modify, or revoke my license or end my participation in the Program.
7. I agree to enter into a Monitoring Agreement and any addenda thereto with the Program as a condition of my participation.
8. I agree to sign Authorization to Use and Disclose Protected Health Information and Consent to Release, Use, and Exchange of Information forms allowing the Program to obtain and exchange information as outlined in such forms, including my alcohol, drug, and mental health treatment records. I understand that alcohol, drug and mental health treatment records are protected under federal and state laws (42 CFR, Part 2; ORS 430.399(5) and ORS 179.505 governing confidentiality of medical records including records related to alcohol and drug abuse, which regulations and statutes provide that such records cannot be released without my written consent unless otherwise permitted in the regulations/statutes; ORS 192.518 relating to protected health information, ORS 192.529 regarding the retention and disclosure of genetic information; and other related state and/or federal laws or regulations relating thereto). I understand I may revoke my consent to exchange and disclosure my alcohol, drug, or mental health treatment records at any time. This revocation must be in writing. I further understand and agree that any use or release of my alcohol, drug, or mental health treatment records by the Program prior to my revocation of my Consent is and shall not be affected by my revocation.
9. I understand that my enrollment in the Program likely will span a considerable period of time and during my enrollment, if the Program deems it necessary, I agree to execute any additional releases for confidential medical records and/or alcohol and drug treatment records which are presented to me by the Program for my signature. I further agree that if I should fail or refuse to sign any such additional releases, my refusal will constitute my voluntary withdrawal from the Program which will be reported to my licensing Board by the Program.
10. **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.**
11. **If my enrollment in the Program was due to my abuse of any substance(s) (drugs or alcohol), I agree that if I revoke my Consent to Release, Use, and Exchange of Information form which, among other things, allows disclosure of my drug and alcohol records, or if I revoke my Authorization to Use and Disclose Protected Health Information, such act(s) will constitute my**

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**voluntary disenrollment from the Program. I understand that under such circumstances, the Program is compelled by ORS 676.190 to remove my name from the list of enrollees who are participating in the Program, which list will be provided to my licensing Board and the Board will be aware of my non-participation in the Program.**

12. You will be enrolled in the Program once you have signed this Consent to Services Enrollment Agreement, Consent to Release, Use, and Exchange of Information and Authorization to Use and Disclose Protected Health Information - including mental health treatment records form(s) and your Monitoring Agreement and any addenda thereto and have paid your deposit. I understand and agree that if I sign this Consent to Services Enrollment Agreement and thereafter, for any reason, fail or refuse to participate in the Program including, but not limited to, my failure to sign a Monitoring Agreement or any addenda thereto or my failure to sign a Consent to Release, Use, and Exchange of Information form, the Program shall immediately report such failure to the DPR who will report to my licensing Board.
13. This Consent to Services Enrollment Agreement shall remain in effect throughout the term of my participation in the Program and end on either the date I am terminated from the Program or the date I successfully complete the Program.

DATED this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
[Signature]

\_\_\_\_\_  
[Printed Name]

\_\_\_\_\_  
[Date of Birth]

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