800-958-7124 **FAX 314-569-9444**

MISSOURI PHYSICIANS HEALTH PROGRAM
The Physician Lifeline: Preserving Physicians' Lives

Consent for the Release of Confidential Information

I, _____ *of* _____
(name of potential or current MPHP participant giving consent) *(ADDRESS of participant giving consent)*

authorize: **MISSOURI PHYSICIAN HEALTH PROGRAM**
1023 Executive Parkway, Suite 16, St. Louis, MO 63141

____*to release to or*
____*to receive from*

Name/Business_____

Phone and Address or fax number_____

Relationship to Participant: **EMERGENCY CONTACT**

the following information: (please check the appropriate line(s))

__Lab Results
__Diagnosis and Treatment Recommendations
__Discharge/Transfer Summary
__Cooperation and Progress
__Identifying Information
__Change in Status
__Quarterly Progress Report(s)
__Psychological Report
__Individual Treatment Plan
__Psychiatric Evaluation
__Family Assessment
__Other:_____

The purpose or need for disclosure is to monitor my progress in a plan of recovery from any illness(es) that has or could impair my ability to practice safely.

I understand that my records are protected under Federal Confidentiality rules (42 CFR Part 2). Federal rules prohibit further disclosure of this information except by written consent of the person to whom it pertains. I may revoke this consent at any time except to the extent that action has been taken in reliance on it (e.g. probation, parole, etc...) and that in any event this consent expires automatically as described below. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Specification of the date, event or condition upon which this consent expires:
This consent expires six months after completion of the Program or as specified:_____.

I further acknowledge that the information released was fully explained to me and this consent is given of my own free will.

_____ _____
(Signature) ***(Date)***

_____ _____
(Witness) ***(Date)***