

**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 **SOBERLINK**

Phone and Address or fax number \_\_\_\_\_

Relationship to Participant (spouse, therapist, psychiatrist, lawyer, supervisor, etc) \_\_\_\_\_

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

- |   |  |
|---|--|
| <input checked="" type="checkbox"/> <b>Lab Results</b>                  | <input type="checkbox"/> <b>Quarterly Progress Report(s)</b> |
| <input type="checkbox"/> <b>Diagnosis and Treatment Recommendations</b> | <input type="checkbox"/> <b>Psychological Report</b>         |
| <input type="checkbox"/> <b>Discharge/Transfer Summary</b>              | <input type="checkbox"/> <b>Individual Treatment Plan</b>    |
| <input checked="" type="checkbox"/> <b>Cooperation and Progress</b>     | <input type="checkbox"/> <b>Psychiatric Evaluation</b>       |
| <input checked="" type="checkbox"/> <b>Identifying Information</b>      | <input type="checkbox"/> <b>Family Assessment</b>            |
| <input checked="" type="checkbox"/> <b>Change in Status</b>             | <input type="checkbox"/> <b>Other: _____</b>                 |

*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)