PERMISSION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION Federal Rule (42 CFR Part 2)

I hereby authorize the exchange of information between the Professional Assistance Program of New Jersey and: (List name(s), affiliation(s), address(es) and telephone number(s):

The information to be released by the Professional Assistance Program will be limited to:

- 1) Initial and working diagnosis;
- 2. Attendance, involvement and compliance with the treatment plan;
- 3. Any regression in status;
- 4. Unilateral cessation or participation on my part;
- 5. Failure to be present at two consecutive appointments;
- 6. Positive urine test result:
- 7. A final summary when appropriate; and/or
- 8. Any and all medications prescribed.

The Staff of the Professional Assistance Program may also submit telephone reports to: List name(s), affiliation(s), address(es) and telephone number(s):

I also authorize that the Professional Assistance Program to notify the treating physician other state Physicians' Health Program/aftercare program of their impressions of ongoing recovery, positive urine results of drugs other than those prescribed and/or knowledge of a relapse.

I understand that this release of information may be withdrawn by me at any time. Such withdrawal would not limit any information which had been released previously.

Program Participant

Date

Witness

This copy to be given to the treating physician/aftercare program/other state physicians' health program. This copy to be returned to the Professional Assistance Program of New Jersey. - This copy to be retained by the Program participant.

This release of information shall remain in effect until

PROFESSIONAL ASSISTANCE PROGRAM STAFF

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