Authorization and Consent to Release Information
<u>from</u> the Alabama Professionals Health Program

Name	**Date of Birth**
Address	**City/State/Zip**

I hereby authorize and request that the APHP release the following information which may be available:

Summaries from the following facilities:

Types of Records to be Released:

_____
( ) Summary of Assessment/Evaluation Findings*
( ) Summary of Discharge Diagnoses*
( ) Summary of Discharge Recommendations*

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( ) Summary of Assessment/evaluation Findings*
( ) Summary of Discharge Diagnoses*
( ) Summary of Discharge Recommendations*

( ) Alabama Professionals Health Program Agreement
( ) Urine Drug Screen Report
( ) Other (Please specify) _____

TO:

Name of Hospital, Company or Individual	**Street Address**
City, State and Zip	**Phone No. & Fax No.**

42 CFR Part 2 – Statutory authority for confidentiality of drug abuse patient records prevents treatment records from being re-released.

I hereby authorize the release of the above information and release and hold harmless the Alabama Impaired Physicians Committee, the Alabama Professionals Health Program, its members, agents or employees from any and all claims for damages arising out of or related to the release of the information specified above.

1. **I understand that I have the right to withdraw this authorization at any time, but that this authorization shall expire, without my written revocation, two (2) years from the date provided below except to the extent it is already being relied upon. I authorize a photocopy of this release to be used in lieu of an original signed document.**
2. **The information contained herein is confidential and is being provided in response to this written authorization. Further disclosure by the receiving party is prohibited.**

Date: _____ _____
Signature of Consenting Party

Witness Signature: _____