Consent to Release, Use and Exchange of Information
Addendum to Consent #1
For Employers Only

Licensee's name _____Date of Birth: _____

I, **_____,** authorize Uprise Health, also known as the Delaware Professionals' Health Monitoring Program ("Program") to obtain, release, use and exchange my confidential health treatment information including, but not limited to, my use of prescription medication or use of impairing or mood altering substances or medications with addictive potential, my drug, alcohol and mental health treatment records from the Program and/or the status of my participation in the Program to persons or entities identified in all prior Consent to Release, Use and Exchange of Information forms previously signed by me, including the individual or entity named below [re-release between the below listed individual or entity is not authorized in accordance with 42 CFR Part 2]:

_____

(The **name** of the person or entity **must be** provided. Please put the name of your employer on the above line.)

The information to be released, used, exchanged and/or disclosed is:

Each item must be initialed; the minimum amount of information will be shared for each stated purpose.

_____ Alcohol, drug or mental health diagnosis

_____ Drug testing collection site reports, including reports of inappropriate behavior

_____Treatment plan(s)

_____Drug testing laboratory reports

_____Monitoring agreement and addendums

_____ Board referral information (for Board referred only)

_____ Completion date of treatment

_____Compliance with monitoring agreement

_____ Summary of services rendered

_____ Other: _____
Specify

The disclosures authorized in this consent are to: monitor, coordinate and ensure compliance with the Program.

I understand that my alcohol and/or drug treatment and mental health records are protected under federal and state laws and regulations (42 CFR Part 2,) governing confidentiality of alcohol and drug abuse patient records and protected health information records generally, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke my consent to release such records at any time except to the extent that prior action has been taken in reliance upon it. I understand that for my revocation of consent to be in effect, it must be in writing. I also understand that I may revoke my consent to release such records at any time except to the extent that prior action has been taken in reliance upon it. The DPR receives a regular report listing all active licensees in the Program. I understand that if I revoke my consents that my name will no longer be on the active list and the DPR will know that I have revoked consent because they will not receive any notification of my completion of or termination from the Program.

I authorize the disclosure, use and re-release by the Program of my alcohol, drug and/or mental health treatment records, which records are protected as noted above. I further authorize the Program to release any other protected health information which it has received pursuant to a valid release of medical information form which I have signed.

I understand if I report abuse of a child or an elder or that I intend to harm myself or others, my confidentiality will be broken and action will be taken in accordance with federal and state laws and regulations.

If not previously revoked, this Consent will automatically expire the later of one year from the date of signing or my successful completion of the Program.

DO NOT RETURN THIS CONSENT INCOMPLETE – PLEASE CALL WITH ANY QUESTIONS

Full Legal Signature of Licensee *OR* Licensee's Authorized Representative | Relationship to Licensee | Date

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