



42 CFR – Part 2 and CFR Parts 160 & 164
RECORDS RELEASE AUTHORIZATION PRIMARY CARE PHYSICIAN

I, _____, give my consent to S.A.R.P.H. to disclose information from my S.A.R.P.H. record to:

(Primary Care Physician name, address, phone number)

for the sole purpose of maintaining my participation in the S.A.R.P.H. program. The information will be limited to:

- A summary of my communications with the S.A.R.P.H. program representative;
- The results of my required evaluations and recommendations;
- Verification of my participation in the S.A.R.P.H. program;
- Verification of my status in good standing;
- Notification of any practice limitations currently required;
- Information about the S.A.R.P.H. program;
- Any contract violations, relapses, or positive ROB results.

I understand that I have no obligations whatsoever to disclose information from my S.A.R.P.H. record and that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon, by notifying S.A.R.P.H. in writing; specifying the effective date of revocation. Without such notice of revocation, this consent shall automatically expire upon termination of my involvement in the S.A.R.P.H. program.

DATE SIGNED

PARTICIPANT SIGNATURE

DATE SIGNED

WITNESS SIGNATURE