42 CFR – Part 2 and CFR Parts 160 & 164
RECORDS RELEASE AUTHORIZATION FROM OVR COUNSELOR

I, _____hereby give my consent to:

_____
(OVR Counselor name, address, phone number, email address)

to disclose to the Pennsylvania Pharmacy Peer Assistance Program (SARPH), information limited to:

- My request for OVR services, to include the estimated length of treatment; type of treatment services provided; attendance; and date and type of treatment termination;
- My diagnosis/prognosis that includes a summary of my authorized treatment services; the nature of the project, payment for SARPH monitoring requirements, including payment for random observed body fluid screens, and the nature and duration of any additional services to be provided by OVR;
- A brief description of adjustments to my treatment plan and conditions required in order for OVR services to be provided;
- A brief description documenting the type and frequency of any relapse into the use of any prohibited substance(s), including alcohol, any medication use for which I do not have a valid prescription, or that has not been approved by my SARPH case manager and coordination of services to address the relapse.

I understand that the information disclosed will be used for the sole purpose of verifying and monitoring my treatment/recovery to determine my individual needs, receive advocacy from SARPH and my continued participation in the SARPH program. I understand that I have no obligation whatsoever to disclose any information from my patient record. I understand my right to revoke this consent at any time, except to the extent that action has been taken in reliance thereon. To revoke, I must notify the SARPH Case Manager in writing, specifying the effective date of revocation. Without such notice of revocation, the consent shall automatically expire upon termination/completion of my involvement in the SARPH and/or OVR programs.

_____ _____
DATE SIGNED PARTICIPANT SIGNATURE

_____ _____
DATE SIGNED WITNESS SIGNATURE

Revised 9/9/15 KS

42 CFR – Part 2 and CFR Parts 160 & 164
RECORDS RELEASE AUTHORIZATION TO OVR COUNSELOR

I, _____, give my consent to the Pennsylvania Pharmacy Peer Assistance Program (SARPH) Case manager to disclose information from my PNAP record to:

_____

(OVR Counselor name, address, phone number, email address)

The information will be limited to:

- My request for OVR services, to include the estimated length of treatment; type of treatment services provided; attendance; and date and type of treatment termination;
- My diagnosis/prognosis that includes a summary of my authorized treatment services; the nature of the project, payment for SARPH monitoring requirements, including payment for random observed body fluid screens, results of all drug testing with dates and type of screen collected and the nature and duration of any additional services to be provided by OVR;
- A brief description of adjustments to my treatment plan and conditions required in order for OVR services to be provided;
- A brief description documenting the type and frequency of any relapse into the use of any prohibited substance(s), including alcohol, any medication use for which I do not have a valid prescription, or that has not been approved by my SARPH case manager and coordination of services to address the relapse.

I understand that I have no obligations whatsoever to disclose information from my SARPH 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 SARPH 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 SARPH program.

_____ _____

DATE SIGNED PARTICIPANT SIGNATURE

_____ _____

DATE SIGNED WITNESS SIGNATURE