42 CFR – Part 2 and CFR Parts 160 & 164
RECORDS RELEASE AUTHORIZATION PHYSICIAN/SPECIALIST

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

____

(Physician/Specialist 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

Revised 5/27/15 KS