42 CFR – Part 2 and CFR Parts 160 & 164
RECORDS RELEASE AUTHORIZATION SIGNIFICANT OTHER/EMERGENCY CONTACT

I, _____, give my consent
To the S.A.R.P.H. Pharmacy Peer Assistance Program Case Manager to disclose information from the S.A.R.P.H. records to my significant other and/or emergency contact:

_____
(Significant Other/Emergency Contact name, address, phone number)

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

- Information about the S.A.R.P.H. program;
- Verification of my participation in the S.A.R.P.H. program and/or the VRP;
- Results of my evaluation and treatment recommendations;
- Verification of my status in good standing;
- Notification of any practice limitations currently required;
- Any relapses or positive drug screens.

I understand that I have no obligations whatsoever to disclose any 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 the S.A.R.P.H. Case Manager 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