PROGRAM FOR RECOVERING DENTAL PROFESSIONALS

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

To the extent possible under federal and state law, I consider all my medical records, including records concerning my activity with the Program for Recovering Dental Professionals, to be privileged and confidential. I, therefore, give my permission for the PRDP representatives to give reports to and receive reports from the person(s) or agency(s) names below. I understand these reports will contain information regarding my involvement with PRDP and will include information regarding any chemical dependence and/or mental illness problems I may have plus information regarding my progress in recovery. Any limitations regarding the content of information in these reports are as defined below. I further acknowledge that the purposes of these reports were explained to me and that this consent is given of my own free will. ***NOTE:*** ***NONAPPLICABLE ITEMS SHOULD BE MARKED "N/A".***

1. Monitor: _____

   Report Limitations: _____

2. Hospitals where I have privileges:

   1. _____ 2. _____ 3. _____

   Report Limitations: _____

3. Representative of hospital administration: _____

   Report Limitations: _____

4. Associate: _____

   Report Limitations: _____

5. Spouse or significant other: _____

   Report Limitations: _____

6. Office manager and/or nurse: _____

   Report Limitations: _____

7. Personal physician and Dentist: _____

   Report Limitations: _____

8. Idaho State Board of Dentistry: **Executive Director or designees**

   Report Limitations: a. Informal, verbal notification of program participation.

   b. If I become out of compliance with this contract, NO LIMITATIONS.

9. PRDP Support Group Staff (including Turnboom Counseling Center or WPHP): _____

   Report Limitations: _____

10. FirstSource Solutions: For the purposes of UA collection and testing

11. Others: a. _____

    b. _____

    c. _____

If not previously revoked, this consent will terminate five years from _____.

SIGNED: _____ Date: _____

WITNESS: _____ Date: _____