

# PRN

Program for Recovering Nurses  
5530 W. Emerald  
Boise, ID 83706  
[www.southworthassociates.net](http://www.southworthassociates.net)

Office: (208) 323-9555  
Toll Free: (800) 386-1695

## RELEASE OF CONFIDENTIAL INFORMATION

I, \_\_\_\_\_ authorize the Program for Recovering Nurses (PRN) to release information about me to \_\_\_\_\_ for the purposes of \_\_\_\_\_ . The address and/or fax number I want information sent to is: \_\_\_\_\_ . Relationship to client: \_\_\_\_\_ .

I agree to the following release(s) of information:

**Note: The client must initial next to each item they wish to authorize for release.**

\_\_\_ Evaluation Results      \_\_\_ Discharge Information      \_\_\_ Diagnosis Information  
\_\_\_ Medication information      \_\_\_ Correspondence sent/received      \_\_\_ Treatment Progress  
\_\_\_ Quarterly work reports      \_\_\_ Program progress      \_\_\_ Urinalysis Testing  
\_\_\_ Client Activity Reports      \_\_\_ Other: \_\_\_\_\_

**If not previously revoked, this consent will terminate five (5) years from your current contract date of: \_\_\_\_\_ .**

**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 Nurses, to be privileged and confidential. I, therefore, give my permission for the Program representatives to give reports to and receive reports from the person(s) or agencies listed above. I understand these reports will contain information regarding my involvement with the Program and will include information regarding any chemical dependence and/or mental health issues in addition to information regarding my progress in recovery. Any limitations regarding the content of information in these reports are as defined above. I further acknowledge that the purposes of these reports were explained to me and that this consent is given of my own free will.**

**If I was referred to the Program by the Board of Nursing or if I am not in compliance with my monitoring contract, I acknowledge there are NO report limitations.**

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

The Program for Recovering Nurses: Protecting the public safety, health and welfare by assisting nurses in their recovery and return to safe practice.