

PRDP

Program for Recovering Dental Professionals
5530 W. Emerald
Boise, ID 83706

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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 Boise Counseling Center or WPHP): _____
Report Limitations: _____
10. First Lab: For the purposes of UA collection and testing
11. Others: a. (Psychiatrist) - _____
b. (Marriage Counselor) - _____
c. _____

If not previously revoked, this consent will terminate five years from _____, 20_____.

SIGNED: _____

Date: _____

WITNESS: _____

Date: _____