PHYSICIAN RECOVERY NETWORK

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 Physician Recovery Network, to be privileged and confidential. I, therefore, give my permission for the Idaho Medical Association PRN Committee representatives to give reports to and receive reports from the person(s) or agency(ies) named below. I understand these reports will contain information regarding my involvement with PRN and will include information regarding any chemical dependence and/or mental illness problems I may have and 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.

1. Physician Monitor: ______________________________

   Report Limitations: ______________________________

2. Hospitals where I have privileges:

   1. ______________ 2. ______________ 3.______________

   Report Limitations: ______________________________

3. Representative of hospital administration:______________________________

   Report Limitations:______________________________

4. Physician 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 Medicine: **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. PRN Physician 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:______________________________