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 Nurses, to be privileged and confidential. I, therefore, give my permission for the Idaho Board of Nursing 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. Worksite Monitor: ____

   Report Limitations: ____

2. Employer: ____

   Report Limitations: ____

3. Treatment Provider:____

   Report Limitations:____

4. Counselor:________ ____

   Report Limitations:____

5. Spouse or significant other:____

   Report Limitations: ____

6. Medication manager/psychiatrist:____

   Report Limitations:____

7. Personal physician and dentist:____

   Report Limitations: ____

8. Idaho State Board of Nursing:

9. PRN Nurse Support Group Staff

   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:______________________________