PRN

Pharmacist Recovery Network
5530 W Emerald St
Boise, ID 83706

Office: (208) 323-9555
Fax: (208) 323-9222

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 Pharmacist Recovery Network (PRN), to be privileged and confidential. I, therefore, give my permission for the PRN to give reports to and receive reports from the person(s) or agency(ies) names 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. Peer Monitor: ____________________

   Report Limitations: ____________________

2. Pharmacist associate: ____________________

   Report Limitations: ____________________

3. Spouse or significant other: ____________________

   Report Limitations: ____________________

4. Office manager and/or nurse: ____________________

   Report Limitations: ____________________

5. Personal physician and Dentist: ____________________

   Report Limitations: ____________________

6. Idaho State Board of Pharmacy: **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.

7. PRN Support Group Staff (including Turnboom Counseling Center or WPHP): ____________________

   Report Limitations: ____________________

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

9. Evaluator/Treatment Provider: ____________________

   Report Limitations: ____________________

10. Others: a. ____________________

    b. ____________________

    c. ____________________

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

SIGNED: ____________________ Date: ____________________

WITNESS: ____________________ Date: ____________________