Mississippi Nurse Voluntary Program (MnVP)

MnVP Release of Information, Waiver of Confidentiality, and Privacy Rule Authorization

I, _____, hereby authorize the release of any and all information regarding my treatment and/or evaluation by any treatment provider, including all ongoing psychiatric and psychological records, at any treatment or health care facility, past or present, including but not limited to, all diagnoses, findings and/or recommendations to the Mississippi Nurse Voluntary Program (MnVP); and I do hereby authorize said treatment facility, its medical director or staff to communicate freely with MnVP and/or its representative(s) regarding my evaluation, treatment, diagnosis, recommendations, and discharge, and to release any document, report or summary to MnVP.

Reciprocally, I hereby authorize MnVP to release any treatment facility and/or program and/or any evaluation, treatment or aftercare entity, any and all information which is in my MnVP file, MBON licensure and/or investigative file, including but not limited to all information pertaining to current or past investigations, evaluations, treatments, and/or monitoring and any pending or past disciplinary action.

I understand that this agreement will expire one (1) year from the signature date and cannot be renewed without my written consent. I understand that I may revoke this agreement at any time, except to the extend that action has been taken thereon, by delivering to MnVP a written revocation.

I further authorize any person or entity to rely on a copy or facsimile of the release, the original of which shall remain in the possession of MnVP.

I hereby waive my right to confidentiality to the MnVP and/or its representatives. Further, I recognize that federal rules prohibit further re-disclosure of drug and/or alcohol abuse/treatment record unless further disclosure is by written consent of the person whom it pertains. Accordingly, I specifically agree with such re-disclosure and authorize MnVP to freely communicate with, via telephone, facsimile, or personal interview, any individual or entity it deems relative to an investigation of my physical, emotional, and mental health, and my ability to practice nursing with reasonable skills and safety to patients. This includes, but is not limited to, any hospital or health care facility, past or present, in which I have received or am receiving treatment, any physician, advanced practice nurse or other health care entity from which I have received medical care, hospital administration and medical staff, business associates, partners, friends and family. Likewise, MnVP may communicate to these individuals

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or entities, the result of evaluations, treatments, and/or recommendations as deems appropriate by MnVP. In so doing, I waive any and all privileges and rights of confidentiality which I would otherwise possess with respect thereto. I agree and understand that there must be a free flow of information to and from MnVP and others as appropriate to ensure my adequate evaluation, treatment and successful recovery.

_____

Participant's Printed Name

_____ _____

Participant's Signature Date

_____

MnVP Representative Printed Name

_____ _____

MnVP Representative Signature Date

Note: This information has been disclosed to you from records, the confidentiality of which is protected by Federal Law. A general authorization for the release of medical or other information is not sufficient for this purpose. This release and authorization is specifically granted in compliance with 42 U.S.C. 290 (dd-2) (Confidentiality of Records of the Identity, Diagnosis, Prognosis, and Treatment of Substance Abuse Patients) and 42 C.F.R. Part 2 (Regulations for confidentiality of Alcohol and Drug Abuse Patient Records). Pursuant to 45 C.F.R. § 164.512(d), the Mississippi Nurse Voluntary Program is not a "Covered Entity" for the purpose of Health Insurance Portability and Accountability Act of 1996 (HIPAA).

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