

## **Third Party Consent to Release Confidential Information**

Participant Name:		IPN Case # SSN #:			
Date of Birth: FL. Nursing License		oer:	Profes	Profession:	
I hereby authorize Inte	ervention Project for Nurses, Inc.	("IPN") to r	elease the informa	ation indicated below to:	
Company Name:					
Name:					
Address:					
City:		_ State:	Zip Code:	County:	
Phone #:		_ Fax #:			
Email:					
<ul> <li>IPN Correspo</li> <li>Toxicology T screen was po</li> <li>Publicly-Ava proceedings i</li> <li>Department of Participant</li> <li>Rescission of</li> <li>Consent Form</li> <li>Oral statement</li> </ul>	fanual ge (copies of documents provided ondence (copies of correspondenc est Results (including date; negat	e sent by IP ive/positive Licensure Bo Withdraw f pant cipant onnel (withou	N to the Participan and if positive, the pard Documents (a from Practice ("V" at limitation)	he substance(s) for which the relating to administrative WOP") completed by the	
and/or federal law, inc	Consent authorizes the release of a luding 42 C.F.R. Part 2. This Co	nsent is for t	he specific purpo	se of	
it. I hereby release IPI	y revoke this Consent at any time N, its employees, and agents from Consent. A copy of this Consent	any liabilit	which may arise		
Unless earlier revoked	, this Consent will expire one year	r from the d	ate signed.		
Participant Printed Name Par		t Signature		Date	

Return to: IPN, P.O. Box 49130, Jacksonville Beach, FL 32240-9130 or via Fax to (904) 270-1633.

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