IPN
INTERVENTION PROJECT FOR NURSES

Consent to Release Confidential Information for Medication Management

Participant Name: _____IPN Case # _____ SSN #: _____

Date of Birth: _____ FL. Nursing License Number: _____ Profession: _____

I hereby authorize Intervention Project for Nurses, Inc. ("IPN") to release the information indicated below to:

Name: _____Credentials: _____

Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Phone #: _____ Fax #: _____

Email: _____

This Consent includes the following information:

- Participant Contract
- Participant Manual
- Intake Package (copies of documents provided by IPN to the Participant during intake)
- IPN Correspondence (copies of correspondence sent by IPN to the Participant)
- Toxicology Test Results (including date; negative/positive; and if positive, the substance(s) for which the screen was positive)
- Publicly-Available Department of Health and Licensure Board Documents (relating to administrative proceedings involving the Participant)
- Department of Health Voluntary Agreement to Withdraw from Practice ("VWOP") completed by the Participant
- Rescission of VWOP Completed by the Participant
- Consent Forms Previously Signed by the Participant
- Oral statements and/or testimony by IPN personnel (without limitation)
- Other, described as follows: _____

I understand that this Consent authorizes the release of information that may otherwise be confidential under Florida and/or federal law, including 42 C.F.R. Part 2. This Consent is for the specific purpose of program participation.

I understand that I may revoke this Consent at any time except to the extent that IPN has already acted in reliance on it. I hereby release IPN, its employees, and agents from any liability which may arise as a result of any disclosure made pursuant to this Consent. A copy of this Consent is as valid as the original.

Unless earlier revoked, this Consent will expire one year from the date of Participant's successful completion of the Program as determined by IPN.

_____	_____	_____
Participant Printed Name	Participant 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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