



Tennessee Professional Assistance Program

545 Mainstream Drive . Suite 414
 Nashville, Tennessee 37228-1219
 615-726-4001 . 888-776-0786
 Fax 615-726-4003
 www.tnpap.org

Authorization to Exchange Information To and From the Employer

I have been informed of the meaning and content of this authorization to exchange information and understand that my consent includes verbal, written and electronic communications between the parties named herein. I also understand my consent may include the reproduction, transference, loan and investigation of documents and information pertinent to my individual situation.

<hr style="border: none; border-top: 1px solid black; margin-bottom: 5px;"/> First, Middle, Last Name (PRINT)	<hr style="border: none; border-top: 1px solid black; margin-bottom: 5px;"/> SSN
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TnPAP may exchange the protected health information indicated below with _____ (PRINT)
 Employer/Facility _____ Phone No. _____
 Address _____

Check all that apply:
 Human Resource/Personnel Office Director of Nursing/Supervisor CEO/Administrator EAP
 Other, specify _____

Extent and Nature of Disclosure:	Purpose of this Disclosure:
<ul style="list-style-type: none"> • Information obtained in and during counseling, examination, testing, groups, and/or sessions and the results thereof, regarding evaluations, assessment, recommendations, treatment, aftercare, psychological, mental, physical, emotional, and/or social conditions that may affect my ability to practice as a licensed healthcare professional in state of TN. • Results of toxicology screening. • Progress reports • Cooperation with TnPAP • Information held under the Drug Office and Treatment Act of 1972 (PL-92255) and the Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment and Rehabilitation Act Amendments of 1974 and the Health Insurance Portability and Accountability Act defined in 42 C.F.R., Part 2. • Other _____ 	<p>The disclosure of the information and records is for the specific purpose to:</p> <ul style="list-style-type: none"> • Provide the necessary, pertinent, and current information required to assist and support me in my treatment and/or recovery. • Provide accurate information and documents to ensure appropriate advocacy for me. • Allow adequate information to adjudge my ability to practice my licensed profession safely. • Provide for the health, safety, and welfare of the public against unsafe practitioners. • Provide information to the appropriate regulating Board for possible disciplinary action of the license.

Revocation/Expiration: This consent is subject to revocation at any time except to the extent that the Tennessee Professional Assistance Program and/or the above named person has taken action in reliance upon it. If not previously revoked, this consent shall terminate on the day of the termination of the monitoring agreement with Tennessee Professional Assistance Program.

I understand no information may be re-disclosed by either party to any other individual or agency unless done so by my written consent that is hereby granted herein.

This consent for release and exchange of information is given freely, voluntarily and without coercion

 Participant's Signature

 Date

 TnPAP Employee's Signature

 Date