Consent to Release, Use, and Exchange of Information

1. Participant Name: _____Date of Birth: _____

2**. I,** _____**,** authorize Uprise Health, aka Christiana Care Monitoring Program ("Program"), to obtain, release, use, and exchange my confidential health treatment information including, but not limited to, **my use of prescription medication or use of impairing or mood altering substances or medications with addictive potential**, my drug and alcohol and, if applicable, mental health treatment records from the Program and/or the status of my participation in the Program to the persons or entities identified below [re-release between the below listed individuals or entities is not authorized]:

[C*omplete and **initial all lines]***

3. ____ Initial — Christiana Care Health System (Employer)

4. ____ Initial — Medtox Diagnostics, St. Paul, MN (Drug Testing Facility) the only information to be released to Medtox is licensee name, drug panel, and testing schedule.

5. ____ Initial — Omega Laboratories, Inc., Mogadore, OH (Drug Testing Facility) the only information to be released to Omega is licensee name, drug panel, and testing schedule.

6. ____ Initial — United States Drug Testing Laboratories, Inc. (USDTL), Des Plaines, IL (Drug Testing Facility) the only information to be released to USDTL is licensee name, drug panel, and testing schedule.

7 ____ Initial — MROExpress, Ft. Lauderdale, FL (Medical Review Officer)

8. ____ Initial — _____ (Treatment Provider **name** and **address** and **telephone number**) **Primary Care Physician**

9. ____ Initial — _____ (Treatment Provider **name** and **address** and **telephone number**) **Dentist**

10. ____ Initial — _____ (Treatment Provider **name** and **address and telephone number**) **Psychiatrist**

11. ____ Initial — _____ (Treatment Provider **name** and **address** and telephone number)

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Christiana Care Monitoring Program
PO Box 8668, Portland, Oregon 97207
Phone: 1-855-575-9350 Fax: 503-961-7142
monitoring@uprisehealth.com
www.christianacaremonitoring.com

The information to be released, used, exchanged and/or disclosed is: *Each item must be initialed*

___	Alcohol and/or Drug evaluation/assessment	___	Drug testing collection site reports
	Progress notes	___	Drug testing laboratory reports
___	Treatment plan(s)	___	Medical Records
___	Discharge summary	___	Employer Information
___	Summary of Services Rendered		
___	Attendance reports	___	Collateral reports
___	Prescription medications including medications with addictive, mood altering and/or impairing potential	___	Compliance with Monitoring Agreement
		___	Other: _____

The disclosures authorized in this consent are to: monitor, coordinate, and ensure compliance with the Program.

I understand that my alcohol and/or drug treatment and mental health records are protected under federal and state laws and regulations (42 CFR Part 2) governing confidentiality of alcohol and drug abuse patient records and protect health information records generally, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke my consent to release such records at any time except to the extent that prior action has been taken in reliance upon it. I understand that for my revocation of consent to be effective, it must be in writing and received by the Program. If I am an employer referred participant in the Program due to my abuse of any substance(s) (drugs or alcohol) and I revoke my Consent to Release, Use, and Exchange of Information form, the Program will cease reporting my compliance to my employer and it is likely my employer will take adverse action against me due to my nonparticipation. If my participation in the Program is or was due to a diagnosis of mental health disorder and I revoke my Consent to Release, Use, and Exchange of Information form, the Program will report such revocation to my employer.

I authorize the disclosure, use and re-release by the Program of my alcohol, drug and/or mental health treatment records, which records are protected as noted above. I further authorize the Program to release any other protected health information which it has received pursuant to a valid release of medical information form which I have signed.

I understand if I report abuse of a child or an elder or that I intend to harm myself or others, my confidentiality will be broken and action will be taken in accordance with federal and state laws and regulations.

If not previously revoked, this Consent will automatically expire the later of one year from the date of signing or my successful completion of or termination from the Program.

DO NOT RETURN THIS CONSENT INCOMPLETE – PLEASE CALL WITH ANY QUESTIONS

Full Legal Signature of Participant Date

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