COMMITTEE FOR PHYSICIAN HEALTH (CPH)

A division of the MEDICAL SOCIETY OF THE STATE OF NEW YORK
99 Washington Avenue, Suite 410, Albany, NY 12210
(518) 436-4723 Fax: (518) 436-7943

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____, hereby authorize and consent to communication
(Full Name of Participant)

BETWEEN the Committee for Physician Health and

Name of Individual or Program: _____

Address: _____ Phone: _____

_____ E-mail: _____

_____

_____

As parties that are authorized to communicate, each party may disclose information to the other party or receive information from the other party in accordance with the terms of this Consent.

Information to be disclosed: *(Please check all that are appropriate)*

- ◴ Summary of information pertinent to CPH participation, compliance and recommendations
- ◴ Treatment records/reports and evaluation/discharge reports including recommendations
- ◴ Monitor Reports
- ◴ Toxicology Reports
- ◴ Re-disclose Report of Independent Medical Evaluations and/or Discharge Summaries
- ◴ Other _____

PURPOSE:
□ To facilitate case management and advocacy efforts
□ Other _____

EMAIL:
I authorize the use of email for communication by above-indicated individual/program to CPH and from CPH:
_____ Yes _____ No

EXPIRATION: THIS CONSENT IS SUBJECT TO REVOCATION AT ANY TIME EXCEPT TO THE EXTENT THAT THE PROGRAM WHICH IS TO MAKE THIS DISCLOSURE HAS ALREADY TAKEN ACTION IN RELIANCE ON THIS CONSENT. IF NOT PREVIOUSLY REVOKED, THIS CONSENT WILL TERMINATE THIRTY (30) DAYS AFTER SUCCESSFUL COMPLETION OF CPH PARTICIPATION UNLESS ANOTHER DATE IS INDICATED.

_____ _____
Signature Date