

**S.A.R.P.H.**  
CRI2B.Emp

**Consent for Release of Information**

I, \_\_\_\_\_,  
(Name and Social Security Number of Participant)

give my consent to **S.A.R.P.H.** to disclose information from my  
**S.A.R.P.H.** and Voluntary Recovery Program (VRP) records

to

\_\_\_\_\_  
(Name of employer, address, phone number)  
for the sole purpose of maintaining my participation in the **S.A.R.P.H.** and VRP  
program in good standing through monitoring of my employment and recovery process.

I understand that the information disclosed will be used solely for the purpose of  
verifying and monitoring my employment and practice as a licensed pharmacist, in order  
to determine my eligibility for continued participation in the **S.A.R.P.H.** program. The  
information will be limited to compliance with the Pharmacy Practice Act and standard  
employment conditions.

I understand that I have no obligations whatsoever to disclose information from  
my **S.A.R.P.H.** and VRP records and that I may revoke this consent at any time except to  
the extent that action has been taken in reliance thereon, by notifying **S.A.R.P.H.** in  
writing; and/or specifying a date, event or condition upon which my consent will expire  
without revocation, which I have done below.

This consent shall automatically expire upon the termination of the  
**S.A.R.P.H. monitoring agreement/contract.**  
(Date, Time, Event or Condition)

\_\_\_\_\_  
(Date signed)

**X** \_\_\_\_\_  
Participant's Signature

\_\_\_\_\_  
(Date signed)

**X** \_\_\_\_\_  
Witness

