S.A.R.P.H.
CRI2B.SCH

CONSENT FOR RELEASE OF INFORMATION

I, ______________________________________, give my consent
(Name and Social Security number of Participant)

to **S.A.R.P.H.** and the Voluntary Recovery Program (VRP), Bureau of Professional and Occupational Affairs, Department of State, Commonwealth of Pennsylvania, to disclose information from the **S.A.R.P.H.** records and the records of the VRP to **Current Dean of Pharmacy and/or Prospective Employers and their agents** for the sole purpose of verifying my participation in the **S.A.R.P.H.** program and/or the VRP. The information will be limited to:

- Verification of my participation in the **S.A.R.P.H.** program and/or the VRP;
- Verification of my status in good standing;
- Notification of any practice limitations currently required.

I understand that I have no obligations whatsoever to disclose any 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 the VRP and **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 completion of my
S.A.R.P.H. monitoring agreement/condition.
(Date, Time, Event or Condition)

_____________________________ **X** _____________________________
(Date Signed) (Participant's Signature)

_____________________________ **X** _____________________________
(Date Signed) (Witness)