S.A.R.P.H.
CRI3B.PCP

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 primary care physician/provider, 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 treatment and recovery process.

I understand that the information disclosed will be used solely for the purpose of verifying and monitoring treatment and recovery, in order to determine my eligibility for continued participation in the **S.A.R.P.H.** program. The information will be limited to **that required to provide a factual context in which effective evaluation/treatment can take place.**

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
<u>**S.A.R.P.H. monitoring agreement/contract**</u>**.**
(Date, Time, Event or Condition)

______________________________ **X** ______________________________________
(Date signed) Participant's Signature

______________________________ **X** ______________________________________
(Date signed) Witness