

PHS RELEASE OF INFORMATION PROCEDURE
860 WINTER STREET,
WALTHAM, MA 02451

PHS PHONE (781) 434-7404

PHS FAX (781) 893-5321

Attached is a Physician Health Services (PHS) release of information form. You may be requesting a letter to document your participation in the program for credentialing purposes, or you may want to authorize PHS to communicate with a third party such as your employer or attorney. This form is also used at the request of PHS to gather information from individuals for the purpose of an assessment.

PLEASE NOTE:

1. TO BE CONSIDERED COMPLETE, PLEASE FILL OUT ALL SECTIONS OF THE FORM.

2. PROVIDE A WRITTEN REQUEST AND SPECIFY THE INFORMATION TO BE RELEASED.

Requests for disclosure of information regarding your participation with the program must be in writing.

3. PROVIDE PHS A COPY OF THE REQUEST FOR INFORMATION FROM A THIRD PARTY.

If you have received a written request for information from a third party, it is important that you provide PHS with a copy of the request along with your release reflecting the specific information being sought. For example, some third parties may be satisfied with a simple verification that a physician is in a monitoring program, whereas others might require a more detailed account of the monitoring process, the physician's compliance with an agreement, or ongoing quarterly reports. It is critical that we understand the extent of the inquiry so that we will know what information to release.

4. LEGAL COUNSEL

We encourage you to rely on your personal legal counsel in completing this form.

5. PROVIDE PHS A MONTH TO RESPOND OR SPECIFY A DEADLINE.

PHS urges you to provide all written requests for release of information one month prior to the time it is required to be released, specifying the date the information is to be provided.

6. PLEASE CALL PHS AT (781) 434-7404. IF YOU HAVE QUESTIONS OR NEED ASSISTANCE.

7. THIS FORM MAY BE FAXED TO PHS AT (781) 893-5321 OR MAILED TO PHS AT 860 WINTER STREET, WALTHAM, MA 02451

Thank you.

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____, authorize Physician Health Services, Inc
860 Winter St., Waltham, MA 02451
PHONE: (781) 434-7404 FAX: (781) 893-5321

TO DISCLOSE TO AND COMMUNICATE WITH:

Name _____

Organization _____

Address _____

Phone _____ *Email* _____

RELATIONSHIP (CIRCLE ONE):

- attorney licensing board colleague family member: _____ spouse patient
- professional coach therapist/psychiatrist evaluator/treatment center primary care physician probation officer
- medical provider (other than PCP) organization: attorney organization: administration/leadership organization: physician staff
- organization: non-physician staff organization: physician assistance committee medical school residency program
- other state physician health program malpractice carrier: _____ other: _____

THE FOLLOWING INFORMATION (Nature of information, as limited as possible):

Examples:

- Description of PHS participation
- compliance letter
- copy of PHS recommendations

THE PURPOSE OF THE DISCLOSURE AUTHORIZED HEREIN IS TO (Purpose of the disclosure, as limited as possible):

Examples:

- Provide employer or credentialer Status or update of compliance
- Address monitoring recommendations
- Address PHS assessment

EXPIRATION (You must specify a date, event, or condition upon which this consent expires):

Examples:

- Upon termination of my involvements with PHS
- One year from below date

I also understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance on it.

FOR DRUG AND ALCOHOL RELATED MATTERS:

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

Date: _____

Signature

Printed Name