PEER ASSISTANCE PROGRAM
2901 N. Classen Blvd., Suite 101
Oklahoma City, OK 73106

OKLAHOMA BOARD OF NURSING
405/525-2277
Fax 405/525-0350
www.nursing.ok.gov

CONSENT TO DISCLOSE INFORMATION BETWEEN PEER ASSISTANCE PROGRAM AND **HEALTH CARE PROVIDER/FACILITY**

1. I, _____ consent to the Peer Assistance Program

And _____ communicating with each
(Health Care Provider/Facility)

other and exchanging all information relating to my participation in the Peer Assistance Program, my employment and any health care I am receiving or have received including:

- My status in the Peer Assistance Program, including my withdrawal or dismissal,
- my status in treatment or rehabilitation, including my progress or absence from such,
- any assessment, diagnostic, treatment, rehabilitation or aftercare services I am receiving or have received from a health care provider and
- My work performance and ability to practice nursing.

2. The purpose of and need for the communication and disclosure of information is to facilitate: a) my participation in the Peer Assistance Program, b) my recovery from chemical dependency, and c) my return to nursing practice in a manner that is conducive to both my recovery and safe patient care.
3. I understand that this consent authorizes the release of information that may otherwise be confidential under Oklahoma and/or Federal Law, including 43AO.S. §1-109 & 42 C.F.R. Part 2.
4. I understand that I can revoke this consent at any time except to the extent that action has been taken in reliance on it. I understand that the Peer Assistance Program has relied on this consent in permitting me to participate in the Program and that in the event I withdraw or am dismissed from the program, the Peer Assistance Program may notify the above provider that I have withdrawn or been dismissed from the program even if I revoke this consent and that the provider likewise may notify the Peer Assistance Program if I leave treatment. If not previously revoked, this consent will terminate 60 days after I complete, withdraw or am dismissed from the Peer Assistance Program.

(Signature) _____ (Date Signed) _____

(Witness) _____ (Date Signed) _____

See Back for Confidentiality of Alcohol and Drug Abuse Patient Records under 42-CFR Part 2

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by federal law and regulations. The program may not say to a person outside the program that a patient attends the program or disclose any information identifying a patient as a alcohol or drug abuser **unless**:

1. The patient consents in writing[1]; OR

2. The disclosure is allowed by a court order; OR

3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation; OR

4. The patient commits or threatens to commit a crime either at the program or against any person who works for the program.

Violation of the federal law and regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs.

Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

(See 42 U.S.C. § 290dd-3 and 42 U.S.C. § 290ee-3 for federal laws and 42 CFR Part 2 for federal regulations.)

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[1] A condition of participation in the Peer Assistance Program is that participants sign consent forms a) authorizing the program to share information with health care providers/facilities and employers and b) consenting to the program reporting the participant to the Oklahoma Board of Nursing in accordance with the program policies. Nurses not wishing to sign such consents are not eligible to participate in the program. Revised 9/1/17; 3/15/18