Texas Physician Health Program

1801 Congress Ave, Suite 9-500, Austin, Texas 78701 Phone: (512) 305-7462 Fax: (512) 463-0216 www.txphp.state.tx.us

Request for Compliance Report and Consent for Release of Confidential Information

PHP Participant/Requestor Information
Name: _____
Address: _____
City, State, Zip: _____
Phone number: _____
Email: _____

I, _____ request that the TXPHP send a compliance report to the below individual/entity.

I request that PHP [ ] Mail [ ] Fax [ ] Email (please designate method of delivery) my compliance report to:

Compliance Report Recipient Information
Name: _____
Address: _____
City, State, Zip: _____
Fax number: _____
Email: _____

I am requesting a compliance report for the following purpose(s):

_____
_____
_____

I consent to the release of the following applicable information as part of my compliance report:

- date of entry into PHP program;
- any results/conclusions pursuant to the Medical Director's intake interview;
- whether I entered into a PHP Agreement;
- the date or expected date of termination of PHP Agreement;
- monitoring terms of my PHP Agreement;
- any periods of voluntary agreement to cease practice; and
- current compliance status or final compliance status upon termination of my PHP Agreement.
  [ ] (please initial)

I authorize the release of the compliance report and hold harmless TXPHP, its members, agents, and employees from any and all claims for damages arising out of or related to the release of the compliance report.
[ ] (please initial)

I understand that I have the right to withdraw this consent at any time.
[ ] (please initial)

I understand that this authorization shall expire, without my written revocation, five (5) years from the date of my signature.
[ ] (please initial)

I authorize a photocopy, electronic copy or facsimile of this release to be used in lieu of an original document.
[ ] (please initial)

I hereby authorize and request that the Texas Physician Health Program (TXPHP) provide a compliance report stating my status with the program.

STATEMENT OF CONFIDENTIALITY TO RECIPIENT: The information obtained pursuant to this release has been disclosed to you from records whose confidentiality is protected by state and federal law. State and federal law prohibits you from making any further disclosures of the information without the specific written authorization of the person to whom it pertains, or except as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosures of this information unless such disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Federal rules restrict any use of this information to criminally investigate or prosecute any person for violations related to alcohol or drug abuse.

DISCLAIMER: TXPHP is NOT a healthcare provider and will sign a HIPAA Business Associate Agreement if requested to do so.

Date _____ Consenting Party's Signature _____

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