

**RELEASE OF INFORMATION AGREEMENT**

I, \_\_\_\_\_, authorize the North Carolina Physicians Health Program (NCPHP) to disclose to the below-named individuals the following information:

Any information pertaining to compliance with my monitoring agreement, recovery, or relationship with the North Carolina Physicians Health Program.

I also authorize the below-named individuals to release any requested information **TO** NCPHP.

**I specifically authorize re-release by NCPHP of**

\_\_\_\_\_  
\_\_\_\_\_

**comprehensive assessment results and summary and**

\_\_\_\_\_  
\_\_\_\_\_

**to** \_\_\_\_\_.

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

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date