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 North Carolina Physicians Health Program.

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

(Please check appropriate agencies and/or write in specific named individuals.)

	Name	Relationship	Telephone #
______ Hospital Personnel			
______ Managed Care Organizations			
______ Malpractice Insurance Companies			
______ Therapist			
______ Attorney			
______ Treatment Center			
______ Family Member			
______ Other			

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