

**Participant's Consent To Release Confidential Information To Third Party**

PARTICIPANT: \_\_\_\_\_ IPN CASE #: \_\_\_\_\_  
DOB: \_\_\_\_\_ Florida Nursing License # \_\_\_\_\_ SS #: \_\_\_\_\_

I hereby authorize Intervention Project for Nurses ("IPN") to release the information indicated below to:

[Identify the specific person(s) and other entities to whom the disclosure will be made.  
This can also include categories of persons whose specific identity is presently unknown]

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

This Consent is limited to the following items below:

- IPN Monitoring Contract
- Correspondence between IPN and Participant
- Verbal Communication
- Intake participant forms
- DOH Communication
- Board of Nursing Documents

Other: \_\_\_\_\_  
\_\_\_\_\_

I understand that this Consent authorizes the Release of Information that may otherwise be confidential under Florida and/or Federal law, including 42 C.F.R. Part 2.

This Consent is for the specific purpose of \_\_\_\_\_.

I understand that I may revoke this Consent in writing at any time except to the extent that IPN has already taken action in reliance on this Consent. I acknowledged and agree that actions taken by IPN in reliance on this consent may include, but are not limited to, admitting me into the IPN program or entering into a Monitoring Contract with me, as well as IPN reporting or deciding not to report my impairment to the Department of Health, Board of Nursing or Probable Cause Panel. I acknowledged and agree that, regardless of any subsequent revocation of this Consent, any disclosure made by IPN in reliance on this Consent may be used by such entities and persons for any purpose permitted by law.

I hereby release IPN, its employees, and agents from any liability which may arise as a result of any disclosure pursuant to this Consent.

Unless earlier revoked, this Consent will expire one year from the date signed.

I hereby acknowledge that I have read this Consent and voluntarily agree to all its terms as of the date below. Participant is entitled to a copy of this Consent. A copy of this Consent shall be as valid as the original.

\_\_\_\_\_  
Participant's Signature

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

\_\_\_\_\_  
Participant's Printed Name

\_\_\_\_\_  
Witness' Printed Name

\_\_\_\_\_  
Date Signed by Participant

\_\_\_\_\_  
Date Signed by Witness \*

Note: \*Witness must physically view Participant signing this Consent and sign this Consent on the same date as Participant.

Return original to: IPN, PO Box 49130, Jacksonville Beach, FL 32240-9130  
Fax: (904) 270-1633