Participant's Consent To IPN's Release of Confidential Information To The Impaired Practitioners Program(s) of Other State(s)

Participant:_____ IPN Case #:_____

D.O.B.: _____ SS#:_____

Florida Nursing License:_____

Other State Nursing License#: _____ State:_____

I ("Participant") hereby authorize Intervention Project for Nurses, Inc. ("IPN"), its employees and its other agents and designees, to release all records and information relating to me, of any kind in any format, written or oral, at any time, with the impaired practitioner program, or equivalent entity, of the following state(s):_____, as well as their employees, and other agents or designees.

Current Out of State Case Manager:_____
Current Case Manager Email:_____@_____._____
Address:_____
City:_____ State:_____ Zip:_____
Phone:_____ Fax:_____

I understand that this Consent authorizes the release of information about me 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 facilitating co-monitoring of me by IPN and the impaired practitioner programs of one or more states other than Florida, or the transfer of my impaired practitioners program participation, including monitoring, of me from IPN to such other state program(s).

I understand that I may revoke this Consent in writing at any time except for the extent that IPN has already take action in reliance on this Consent. I acknowledge and agree that actions taken by IPN in reliance on this Consent may include, but are not limited to, assisting my transition to the impaired practitioner program of another state, or engaging in co-monitoring of me with such other state program.

I acknowledge 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 date of my successful completion of the IPN program with such date determined solely by IPN, or one year from the date of successful completion of the impaired practitioners program of the state(s) listed above, whichever date is later.

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

_____	_____
Participant's Signature	Witness's Signature
_____	_____
Participant's Printed Name	Witness's 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, P.O. Box 49130, Jacksonville Beach, FL 32240-9130
Fax: 904-270-1633

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