



INDIANA STATE NURSES ASSISTANCE PROGRAM
 2915 N High School Rd, Indianapolis IN 46224
 (317) 295-9862 • (800) 638-6623 • Fax (317) 297-3525
 www.IndianaNurses.org

CONSENT TO RELEASE INFORMATION - General

I, _____ Consent to the
(First Name, Last Name - Please Print) (Date of Birth)

Indiana State Nurses Assistance Program (ISNAP) to release and/or exchange information
 contained in my medical record with: _____
(Full Name of Person or Facility, Please Print)

Under the conditions specified below: *(Specific Type of Information to be disclosed)*

- | | |
|---|--|
| <input type="checkbox"/> Intake/Assessment Evaluation(s) | <input type="checkbox"/> Treatment Summary |
| <input type="checkbox"/> Admission/Discharge Information | <input type="checkbox"/> Laboratory Reports |
| <input type="checkbox"/> Psychiatric/Psychological Evaluation | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Monthly/Quarterly Reports | <input type="checkbox"/> Summary of Compliance |
| <input type="checkbox"/> Full Release of ALL Medical Records | <input type="checkbox"/> Specific Information (Assessment) |

PURPOSE OF DISCLOSURE: *ISNAP may use the information and records disclosed to determine my status in monitoring. If I fail to participate in, or am dismissed from ISNAP, further disclosure to the Indiana Attorney General's Office/Indiana State Board of Nursing (ISBN) is authorized. If further disclosure occurs, the Attorney General's Office may use the information and the records disclosed to administer and enforce the laws of Indiana. The purpose for such disclosure is:*

- | | | |
|---|---|--|
| <input type="checkbox"/> Evaluation/Assessment | <input type="checkbox"/> Treatment Planning | <input type="checkbox"/> Medication Management |
| <input type="checkbox"/> Compliance in Monitoring | <input type="checkbox"/> Work Site Monitoring | <input type="checkbox"/> Coordination of Treatment |

REVOCAION OR EXPIRATION OF AUTHORIZATION: *By sending a written revocation, I may revoke this authorization at any time, except to the extent that action has already been taken in reliance on this authorization. Unless expressly revoked earlier, this authorization expires on the date that this file is closed with ISNAP.*

COMMUNICABLE DISEASES: *This release includes, if applicable, information about serious communicable diseases and infections (which includes AIDS, AIDS Related Complex, and HIV Infection), Tuberculosis, Hepatitis B and C, Venereal Diseases, and alcohol and drug abuse records protected under Code 42 of the Federal Regulations, Part II.*

APPLICABLE LAW: *This information released is subject to the provisions of Indiana State Regulations (IC 16-39-16) AND Federal Confidential Rules (42 CFR Part II).*

PARTICIPANT'S SIGNATURE

Date Signed

IF Telephone Release, FIRST WITNESS SIGNATURE

Date Signed

IF Telephone Release, SECOND WITNESS SIGNATURE

Date Signed