TPRN
Tennessee Pharmacy Recovery Network

Authorization and Consent for Release of Information from TPRN

I, _____ *(participant's name)* authorize the Tennessee Pharmacy Recovery Network staff to disclose/release the following information (please check all that are approved for disclosure/release):

- ❍ Copies or summaries of all information related to assessment and or treatment facility's information and/or recommendations.
- ❍ Copies or summaries of all information related to TPRN Program participation, compliance, aftercare, monitoring, including screens performed; and,
- ❍ Other information_____

Name or description of program, agency, entity, individual(s) receiving the information:

_____
_____
_____

Purpose of Release of Information (select all that apply):

- ❍ To facilitate all support services provided by TPRN.
- ❍ To facilitate case management, advocacy efforts, and/or aftercare follow-up; and,
- ❍ Other:_____

_____

This consent for release of information is given freely, voluntarily and without coercion. I understand the records released may contain drug or alcohol treatment information or mental health information. I understand this consent is subject to written revocation at any time, except to the extent that the TPRN program, which is to make this disclosure, has already taken action in reliance on this authorization and consent. As a participant, I have the ability to submit a written revocation to this consent authorization at any time. Such revocation must be provided in writing to the TPRN Program Director. If not previously revoked, this consent will terminate one year following successful completion of TPRN program participation, or one year following the completion of the terms of the aftercare contract, unless otherwise indicated here: ____ /____ /_____.

This authorization to release information is fully understood and is voluntary on my part. As a TPRN program participant, I understand that I am entitled to receive a copy of this signed consent. Such request for a copy of this signed consent may be submitted directly to the TPRN Program Director.

Participant's Signature_____
Date of Signature_____
Witness Signature_____
Date of Signature_____