



Peer Assistance Services

**CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION
(School of Dental Medicine)**

I, _____ hereby authorize Peer Assistance Services, Inc. to release the following information, concerning me, to:

Univ. of CO School of Dental Medicine (303)724-6900
(Name of person or organization) (Phone)
Mail Stop F833 13065 E. 17th Ave Aurora, CO 80045 (303)724-7330
(Street Address) (City) (State) (Zip) (Fax)

The purpose of this disclosure is: _____.

Items and information to be disclosed are:

- Treatment records
- Testing results
- Emergency-related information
- Reports of compliant and/or non-compliant behavior
- Assessment summary and/or recommendations
- Screening tool information
- Ability to practice with reasonable skill and safety
- Other _____

(specific record or records)

The confidentiality of alcohol and drug abuse records maintained by Peer Assistance Services, Inc., is protected by Federal laws and regulations. Generally, we may not say to a person outside the program that a client involved with Peer Assistance Services, Inc., attends the program or disclose any information identifying a client as an alcohol or drug abusers—unless: 1) You consent to the disclosure of information in writing; 2) The disclosure is ordered by a court; or as otherwise mandated by State and/or Federal law; 3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. If not sooner revoked, this consent shall expire two (2) years after my discharge from Peer Assistance Services, Inc. (42 C.F.R. § 2.31).

A copy of this document will have the same force and effect as the original.

Client Signature

Date

PEER ASSISTANCE SERVICES, INC. Start believing.

2170 South Parker Road, Suite 229 | Denver, Colorado 80231
TEL 303.369.0039 TOLL-FREE 1.866.369.0039 FAX 303.369.0982
www.peerassist.org | www.codrugfreeworkplace.org

Revised 8/25/09



Peer Assistance Services

**CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION
(School of Dental Medicine)**

I, _____ hereby authorize,
(Print client's first, middle, last name)

School of Dental Medicine - Univ of CO, Denver to release the following information concerning me to:
(first, middle, last name or name of entity)

Peer Assistance Services, Inc.
2170 S Parker Road, Suite 229
Denver, CO 80231

The purpose of this disclosure is to enable the above named to release and discuss the following information with Peer Assistance Services:

- Employment performance
- General conduct
- Emergency-related information
- Reports of compliant and/or non-compliant behavior
- Ability to practice with reasonable skill and safety
- Other (specify type of information)_____

Client Signature

Date