Peer Assistance Services

# CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION
## (Colorado Board of Dental Examiners)

I, ______________________________________________ ("Client") hereby authorize Peer
(Print client's first, middle, last name)

Assistance Services, Inc. to release and disclose the following information concerning me to:

Colorado State Board of Dental Examiners
1560 Broadway, Suite 1300
Denver, CO 80202

The purpose of this release and disclosure is to enable the Colorado Board of Dental Examiners to monitor, assist and/or follow the progress of the Client and to use such information in connection with an investigation, disciplinary action, or any other purpose authorized by the Dental Practice Law of Colorado, C.R.S. § 12-35-101, et seq.

Pursuant to 42 C.F.R. §§ 2.31, 2.32 and 2.33, I further consent to the release and disclosure of this information identified below. This consent includes information, if any, the re-disclosure of which would be prohibited by 42 C.F.R. §2.32, unless expressly permitted by my written consent below.

Items and information to be released 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
- ❑ Records received from other sources pertaining to client.
- ❑ Other________________________________________________
  *(specific record or records)*

I further consent to the use and disclosure by the Colorado Board of Dental Examiners of any items or information released above for use in connection with investigation, disciplinary action , or any other purpose authorized by the Dental Practice Law of Colorado, C.R.S. § 12-35-101, et seq.

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 three (3) years after my discharge from Peer Assistance Services, Inc. (42 C.F.R. § 2.31)

I understand that if I am a licensee in a Peer Health Assistance Diversion Program and have a signed Diversion Program contract with Peer Assistance Services, Inc., my revocation of this consent may result in a report by Peer Assistance Services to the Colorado Board of Dental Examiners for determination of noncompliance.

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

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