COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
PROFESSIONAL HEALTH MONITORING PROGRAMS
P.O. BOX 10569
HARRISBURG, PA 17105-0569
800-554-3428
717-783-4857
www.dos.pa.gov/phmp

Records Release Authorization

I, _____ give my consent to the Professional Health Monitoring Programs (PHMP), Bureau of Professional and Occupational Affairs to disclose the results of the drug and alcohol and/or mental health evaluation completed by the PHMP-approved evaluator to the:

Pennsylvania State Board of:_____ **Telephone:**_____

Board Address:_____

The purpose of the disclosure of this information is to enable the Board to make an informed decision regarding my application for licensure.

I understand that I have no obligations whatsoever to disclose any information and I may revoke this consent at any time by notifying the PHMP case manager in writing prior to release of the information; and/or specifying a date, event or condition upon which my consent will expire without revocation, which I have done below.

This consent shall expire one year from date of the applicant's signature or as otherwise indicated below.

_____
Date, Time, Event or Condition of Expiration

Applicant Signature **Date** **Witness Signature** **Date**