Colorado
Physician Health Program

CONFIDENTIALITY AGREEMENT

Client #_____

The following agreement is entered into this _____ day of _____, 20_____,

between the Colorado Physician Health Program (CPHP) and _____ (participant).

The purpose of this agreement is to document the confidentiality provided to the participant and the limits of this confidentiality to assure protection of public health, safety and welfare.

Confidentiality: You will be assigned a code number to assure your anonymity within the program.

Colorado law and federal law govern confidentiality of your name and information about your participation in certain instances.

If your participation at CPHP involves an alcohol or drug problem, federal law provides only three conditions under which CPHP can release any information about your participation: 1) you consent in writing; 2) if the disclosure is allowed by a court order; 3) if the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit or program evaluation.

Violation of the federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations. Federal law and regulations do not protect any information about a crime committed by a participant, either at the program or against any person who works for the program or about any threat to commit such a crime. Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities. (See 42 U.S.C. Sections 290dd-3 and 290ee-3 for federal laws and 42 C.F.R. Part 2 for federal regulations.)

Consent: In order to administer the program effectively, CPHP needs your consent (as evidenced by your signature below) for disclosure under certain circumstances; CPHP shall not have a duty to report unless you meet one of the situations listed below:

1) A determination by CPHP clinical staff that you may present a danger to yourself or others; Or that you may present a significant risk in your medical practice;

2) A determination by CPHP clinical staff that you have failed to comply with the terms of your treatment/monitoring program and that in the opinion of CPHP clinical staff you may present a danger to yourself, others or your medical practice;

3) A determination by CPHP clinical staff that an obligation to report exists based on violation of one or more provisions of the Colorado Medical Practice Act (CRS 12-36-117 Unprofessional conduct.) in which harm to a patient may have occurred.

4) Pursuant to a subpoena issued by the CMB, in connection with a written complaint alleging unprofessional conduct, as provided in Section 12-36-118, C.R.S.; or in connection with an investigation related to a licensure application, as provided in Section 12-36-111, C.R.S.

Execution of this agreement constitutes your consent to disclose your identity and the entire contents of your file to the Colorado Medical Board (CMB) if you meet one of the above conditions; this may include redisclosure of reports made by outside providers or programs even if your involvement with CPHP was or is on a voluntary basis.

Your file, which may be reviewed by you, may contain information related to an evaluation ordered by the CMB or an employer, as well as self-referral information. You may revoke your consent of disclosure at any time, except to the extent that CPHP has already taken action in reliance on previous consent as expressed in this agreement. Such revocation must be presented to CPHP in writing. Revocation of consent shall not prevent disclosures by CPHP to the CMB, law enforcement authorities or third persons, if otherwise required by law. If not previously revoked, your consent will terminate automatically 90 days after your discharge from the Colorado Physician Health Program. Your discharge date is the date CPHP inactivates your case.

I acknowledge my participation in the Colorado Physician Health Program, which involves specific provisions for confidentiality, consent and revocation of consent. I further understand the Colorado Physician Health Program's reporting obligations, which are limited to the circumstances described above.

Date_____ Signature:_____
(Month/Day/Year)

Printed Name:_____