FORM V

Ohio Board of Nursing *www.nursing.ohio.gov*
17 S. High Street, Suite 660 • Columbus, Ohio 43215-3466 • 614-466-3947

Waiver for Release of Information from the Treatment Provider

I,_____, hereby authorize the Coordinator of the Alternative Program for Chemical Dependency/Substance Use Disorders (Program) or designee to receive from:

_____

such information as requested, which relates to my treatment for chemical dependency and is necessary to allow the Coordinator to determine my status and progress in treatment, and compliance with my Alternative Program Agreement. I understand that this information is confidential and is protected under 42 CFR Part 2 and cannot be disclosed without my written consent.

This waiver will terminate when I am no longer a Participant in the Program.

_____ _____
Participant Signature Date

Effective April 2015