Ohio Physicians Health Program

VOLUNTEER PEER MONITOR FORM

OPHP VOLUNTEER PEER MONITOR DUTIES & RESPONSIBILITIES

The Ohio Physicians Health Program, Inc. (OPHP) is a nonprofit organization which offers confidential assistance to physicians and other healthcare professionals who may be affected by mental, emotional and behavioral illness, substance-related and addictive disorders, or other issues impacting their health and wellbeing. The role of the Volunteer Peer Monitor is to assess a participant's compliance and provide quarterly status reports. We appreciate the willingness of monitors to assist colleagues and serve in this very important role.

Effective monitoring is composed of these essential activities:

- **Assessing Compliance:** The participant and the monitor should arrange a time to review the participant's OPHP Agreement and meet regularly to discuss the participant's health and wellbeing. Monitors are encouraged to make the following inquiries as applicable:
  - Ask about AA/NA attendance and if the participant has a sponsor.
  - Assess the participant's overall attitude.
  - Note the participant's appearance and grooming.
  - Ask about family life, spouse or significant other, and other relationships.
  - Inquire about relationships in the work place. Is there a reasonable work schedule?
  - Explore any major concerns (i.e., Board problems, stressors, etc.)
- **Reporting:** Status reports are required on a quarterly basis. These report can be completed online via OPHP's third-party administrator, Spectrum, or they can also be found on our website, www.ophp.org.

CONTACT INFORMATION

Participant Name: _____

Volunteer Peer Monitor Name: _____

Degree/Specialty: _____

E-mail Address (required for online reporting): _____

Mailing Address: _____

Cell Phone Number: _____ Work Phone Number: _____

Preferred Method(s) of Contact: ☐ Cell Phone ☐ Work Phone ☐ E-mail

_____ _____

Volunteer Peer Monitor Signature Date

Ohio Physicians Health Program

AUTHORIZATION AND CONSENT TO RELEASE INFORMATION FORM

OPHP PARTICIPANT INFORMATION

Name:

Address:

City: **State:** **Zip:**

Primary Phone Number: **Other Phone Number:**

E-Mail Address:

I, _____ (name of Participant) hereby authorize the Ohio Physicians Health Program ("OPHP") to disclose the below specified information to the following authorized individual/organization for the purpose of _____.

Information to be released shall include any or all of the following:

Diagnosis; copy of monitoring agreement; compliance and involvement with the treatment plan and/or monitoring agreement; any change or regression in status, progress or compliance; unilateral cessation of participation or advocacy relationship either on my part of that of OPHP; results of toxicology tests; quarterly reports and/or final summary; and other reports or materials in my file.

RELEASE INFORMATION TO THE FOLLOWING INDIVIDUAL/ORGANIZATION

Company: **Contact Name:**

Address:

Primary Phone Number: **Fax Number:**

E-Mail Address:

1. I understand that my records are protected under the federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without my written consent, unless otherwise provided for in the regulations.
2. I understand that I have the right to withdraw this authorization at any time to the extent the lawful recipient has not already acted in reliance upon this document. Otherwise, this authorization shall expire without my written revocation, ninety (90) days after the completion of my agreement with OPHP. I authorize a photocopy of this release to be used in lieu of an original signed document.
3. Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of this information unless the further disclosure is expressly permitted by my written authorization or as otherwise permitted by 42 C. F. R. Part 2.
4. OPHP will not condition treatment, payment, enrollment, or eligibility on my authorization and consent for the release of information. However, One-Bite Program ("Program") participants are advised that practitioners are deemed to have waived any right to confidentiality that would prevent the monitoring organization conducting the Program or from making reports required by Ohio law, including O.R.C. § 4731.251, which requires OPHP to refer eligible practitioners to evaluation and/or treatment, and to report to the State Medical Board of Ohio any practitioner who is determined to be ineligible to participate in the Program.

_____ _____

Signature of Participant **Date**