Ohio Psychological Association Colleague Assistance Program
Provider Professional Reference Release of Information

In order for the Ohio Psychological Association Colleague Assistance Program to access and verify my professional qualifications and suitability as an OPACAP clinician, I hereby authorize the OPACAP to make inquiries and consult with all persons, places of employment, and non-governmental entities who have information bearing on my moral, ethical and professional qualifications and competence to carry out the position I have applied for.

I consent to the release of information about my ability and fitness for OPACAP and I authorize release of such information and copies of related records, documentation to OPACAP to include not only the requested information for verification but information concerning any/each lawsuit, civil action, or other claim brought against me for malpractice or negligence; each disciplinary actions under consideration or taken; any open or previously concluded investigations; and any changes in the status of a credential and all supporting documentation related to the information provided.

I release from liability all those who provide information to the OPACAP in good faith and without malice in response to such inquiries.

Full Name:_____

Print name Date (mmddyyyy)

Signature:_____

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