Name of Client____ Birthdate _________________ EAP Case Number _______________

I hereby authorize ____
(Name and Address of Individual or Organization)

to release to____
(Name and Address of Individual or Organization to Receive Information)

the following information from my EAP clinical record for the time period: ____.

PLEASE INITIAL NEXT TO ANY ITEMS WHICH APPLY.

☐ **CLINICAL INFORMATION**
Information relating to the clinical services I receive, to support continuity of care or inform them of my status.

☐ **SUPERVISORY REFERRAL**
I have been referred to the EAP by my employer. I authorize CHI St. Alexius Health EAP to release the following information to my employer:

(A) whether I have kept an initial or subsequent appointments, (B) whether a course of treatment was recommended by the EAP, (C) whether I am following the recommended course of treatment, and/or (D) whether I have completed the treatment recommended.

I also authorize CHI St. Alexius Health EAP to exchange with ____
(Supervisor or Other Designee)

information received from____ regarding
(Provider)

____
(Specific information to be shared)

☐ **SAFETY SENSITIVE JOB**
I acknowledge that I am employed in a job classification which has been designated “safety sensitive” by my employer. In the event that my therapist has reason to believe that I am unable to perform my work safely, I authorize CHI St. Alexius Health EAP to disclose to my employer my name, my job classification and the nature of my impairment in order to protect against a threat to life or serious bodily injury.

☐ **OTHER** *(Describe the information to be released, to whom it will be released and for what purpose)*

____.

ALL RECORDS PERTAINING TO PSYCHIATRIC/MENTAL HEALTH, ALCOHOL AND/OR DRUG DEPENDENCY, AND/OR HIV/HIV RELATED ILLNESS WILL NOT BE RELEASED UNLESS SPECIFICALLY AUTHORIZED BELOW IN WRITING.
I specifically authorize the release of the following records:
❑ Psychiatric/Mental Health ________ (Initials) ❑ HIV ________ (Initials) ❑ Drug and/or Alcohol Dependency ________ (Initials)

This authorization shall remain in effect until the following date, event, or condition: ____
If no date, event, or condition is specified, this authorization will expire in one year.

1. This authorization remains in effect until the above date, event, or condition, unless specifically revoked by written notice to the individual or organization. I understand that this authorization may be revoked at any time. Any information released prior to my written revocation of this authorization shall not be breach of confidentiality.
2. I understand that authorizing the disclosure of this clinical information is voluntary. I can refuse to sign this authorization. I need not sign this authorization in order to assure clinical services.
3. I understand that I may inspect or request copies of any information disclosed under this authorization and that I am entitled to a copy of this authorization from once I have signed it.
4. I understand that if the individual or organization that receives the information is not a health care provider or health plan covered by federal privacy regulations the information described above may be redisclosed and no longer protected by these federal regulations.
5. A photocopy of this authorization is as effective as the original.

❑ CHECK IF APPLICABLE – NOTICE TO WHOMEVER DISCLOSURE IS MADE CONCERNING CHEMICAL DEPENDENCY RECORDS: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal Regulations (42-CFR Part 2) prohibits you from making any further disclosure of it without the specified written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for release of information is **NOT** sufficient for this purpose.

_______________________________________ _____________________________
Signature of Client or Legal Representative Date

_______________________________________ _____________________________
Relationship (If patient unable to sign, state reason.)

CHI St. Alexius Health

Authorization for Release of Information