MANAGEMENT REFERRAL FORM /AUTHORIZATION FOR RELEASE OF INFORMATION

To initiate a Management Referral please: First call 1-800-243-5240 for the initial consultation. Then, after meeting with the employee and having them sign this form, immediately fax it to the Consultant named below at 888 892-8832.

MANAGEMENT INFORMATION:

Referring Company: Pima County Government **Referring Person**: ______________________________

Title: ______________________ **Telephone:** ______________________ **Email address:** ______________________________

EMPLOYEE/MEMBER INFORMATION:

Name: ______________________ **DOB**: ________________________ **Position/title:** ____________________________

Telephones: Work: ______________________ **Home:** ____________________________

Cell: ______________________ **Insurance Information:** ____________________________

Department: ______________________ **Does employee/member work in a safety sensitive position?** ☐ **Yes** ☐ **No**

Type of referral being made:

☐ Formal Referral (no job consequences for not following through. **Do not check this box if referral is mandatory**)

☐ Mandatory Referral (there are job consequences for not following through with the EAP referral)

☐ Last Chance Agreement

Deadline by which employee/member must call the EAP for an appointment: ____________________________

Reason for Referral (complete or attach documentation describing reason/job performance issues): __________________________

Expected changes as a result of referral: ____

To the Employee/Member: By signing this form, you are authorizing the EAP to release the following information to the below listed company representatives (please check all that apply):

The following company representatives have the right to receive information from the EAP

Name: ______________________ **Title:** ______________________ **Telephone:** __________________________

Name: ______________________ **Title:** ______________________ **Telephone**: __________________________

Name: ______________________ **Title:** ______________________ **Telephone:** __________________________

This authorization expires on the following date: ____________________________

If the expiration date is not specified, this authorization is for continuing disclosure valid for 365 days after the date of the employee/member signature.

Information to be released:

☐ Attendance (or failure to attend) at all provider recommended treatment

EMPLOYEE/MEMBER PRIVACY/HIPAA INFORMATION:

- You may revoke this Authorization at any time by submitting a written revocation to your EAP at 6501 S. Fiddlers Green Circle, Suite 330, Greenwood Village, CO 80111
- A revocation will not apply to information that has already been used or disclosed in reliance on this Authorization.
- Once information is disclosed pursuant to this Authorization, it may be re-disclosed by the recipient and the information may no longer be protected by HIPAA.
- The plan may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this Authorization.
- You will be provided with a copy of this Authorization form upon completion and execution.

______________________________	________________	______________________________	________________
Signature of Employee/Member	**Date**	**Signature of Witness**	**Date**

FAX COMPLETED DOCUMENT TO: ______________________________ ______________________________

(Consultant name) **(Fax number)**

Consultant contact information: ______________________________ ______________________________

(Telephone number) **(Email address)**

NOTICE TO RECIPIENT(S) OF INFORMATION: Information disclosed to you pertaining to alcohol or drug abuse treatment is protected by federal confidentiality rules (42 CFR Part 2), which prohibit any further disclosure of this information by you without the expressly written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.