Mandatory Management Referral Form / Authorization to Release Information

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

MANAGEMENT INFORMATION:

Referring Company: _____ Referring Person: _____

Title: _____ Telephone: _____ Email address: _____

EMPLOYEE INFORMATION:

Name: _____ DOB: _____ Position/title: _____

Telephone Numbers--Work: _____ Home: _____ Cell: _____

Insurance Information: _____ Department: _____

Does employee work in a safety sensitive position? ☐ Yes ☐ No

Deadline by which employee must call EAP for an appointment? _____

Reason for Referral (complete or attached documentation describing reason/job performance issues): _____

_____

Expected changes as a result of referral: _____

To the Employee: By signing this form, you are authorizing EAP to release the following information to the below listed company representatives:

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

Name/Title: _____ Telephone: _____ Email: _____

Name/Title: _____ Telephone: _____ Email: _____

Name/Title: _____ Telephone: _____ Email: _____

This release of information 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/ membersignature.

Information to be released: Confirmation of Attendance form for all sessions

This release of information covers the following dates: _____ **through** _____

Date from *Date through*

EMPLOYEE PRIVACY/HIPAA INFORMATION:

- You may revoke this Authorization at any time by submitting a written revocation to EAP at 10260 Meanley Drive, 2nd Floor, San Diego, CA 92131
- 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 **Date** **Signature of Witness** **Date**

FAX COMPLETED DOCUMENT TO: _____ 1-888-892-8832

Consultant's name *Fax number*

Consultant Phone: _____ Email: _____

NOTICE TO RECIPIENT(S) OF INFORMATION: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). Information disclosed to you pertaining to certain conditions, such as treatment for alcohol or drug abuse, HIV/AIDS and other sexually transmitted diseases, behavioral health, and genetic marker information is protected by various federal and state laws that prohibit any further disclosure of this information by you without the express written consent of the person to whom it pertains or as otherwise permitted by such laws. Any unauthorized further disclosure in violation of state or Federal law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient consent for release of these types of information. Federal rule 42 CFR Part 2 restricts use of the information disclosed to criminally investigate or prosecute any alcohol or drug abuse patient.