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: _____ **Referring Person**: _____

Title: _____ **Telephone:** _____ **Email address:** _____

EMPLOYEE INFORMATION:

Name: _____ **DOB**: _____ **Position/title:** _____

Telephones: Work: _____ **Home:** _____

Cell: _____ **Insurance Information:** _____

Department: _____ **Does employee 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 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: By signing this form, you are authorizing the 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/member signature.

Information to be released (please check all that apply):

☐ Alcohol/Drug Evaluation/Treatment ☐ Attendance and compliance (or failure to attend and comply) with all provider recommended treatment

☐ All provider recommendations ☐ First session scheduled and attended (for formal referrals only)

☐ By checking this box I agree the information above may be transmitted by email

This release of information covers the following dates: _____ _____

Date From Date Through

EMPLOYEE PRIVACY/HIPAA INFORMATION:

- You may revoke this Authorization at any time by submitting a written revocation to your EAP at 10260 Meanley Drive, Second 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: _____ _____

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

Consultant contact information: _____ _____

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

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.