

BEST CARE EMPLOYEE ASSISTANCE PROGRAM

Authorization to Release Information

EAP Client Name: _____ Date of Birth: _____

I authorize Best Care Employee Assistance Program to ___ Release to and/or ___ Obtain from (please check all that apply):

___ Employer/Human Resources/Supervisor _____

___ Referral or Treatment Provider _____

___ Other (please specify) _____

The following information (check appropriate area):

___ Attendance Only

___ Attendance, Clinical Assessment, Counseling/Treatment Recommendations, and Compliance/Progress with Recommendations

___ Substance Use, Abuse, and Dependency Information – I understand that my substance use disorder records are protected under Federal regulations. 42 CFR part 2 prohibits unauthorized disclosure of these records, and these records generally cannot be disclosed without my written consent except as permitted by law.

___ Psychological or Psychiatric Information

___ Re-release of Information (please specify) _____

___ All Available Information

___ Other (please specify) _____

For the following purpose (check appropriate area):

___ Communication between Best Care EAP and my employer on my counseling and workplace issues.

___ Provide case-related information to enable specialized or long-term counseling or for psychological, psychiatric or Substance Use treatment.

___ Monitor counseling or treatment progress following referral by Best Care EAP.

___ Other (please specify) _____

This authorization is effective for twelve months from the date signed, or on _____ as I have requested, to fulfill the purposes of this authorization, unless sooner revoked. Information released according to the authorization may be subject to redisclosure by the recipient and may no longer be protected by privacy regulations. I understand I may revoke this authorization at any time by notifying my Best Care EAP counselor or the Manager of Clinical Services. Release of information will cease upon receipt of my revocation. I understand such revocation will not apply to information that may have been released prior to revocation. Best Care EAP and its affiliates cannot condition services based on signature on authorization for disclosure.

Date

Client Signature