Best Care Employee Assistance Program (EAP) and Methodist Community Counseling Program (CCP)

Authorization to Release Records

Client Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Previous/Maiden Name: _____

I authorize the disclosure/release of my information (Request must have complete addresses):

To: Name _____
Address _____
City/State/Zip _____
Phone/Fax _____
Email _____

From: Name _____
Address _____
City/State/Zip _____
Phone/Fax _____
Email _____

☐ **I authorize this to be a reciprocal disclosure/release of my information, meaning that the individuals/organizations listed above may both disclose/release the information selected below and receive the information selected below. I also authorize these individuals/organizations to discuss the information selected below with one another.**

NOTE: This selection may be required for the services you receive from Best Care Employee Assistance Program or Methodist Community Counseling Program

Information to be disclosed/released: Date(s) of service requested: From _____(date) to _____(date).

- ☐ All of my Mental Health and Behavioral Health Records (excluding psychotherapy notes)
- ☐ My Entire EAP and CCP Medical Record
- ☐ My Diagnosis
- ☐ My Attendance at EAP/CCP Visits
- ☐ My Attendance, Clinical Assessment, Counseling/Treatment Recommendations, and Compliance/Progress
- ☐ My Billing Records
- ☐ My Substance Use Disorder Records:
  - ☐ All
  - ☐ Only the following substance use disorder records: _____
- ☐ Other: _____

The purpose of releasing or obtaining the above information is:

☐ Continuity of Care ☐ Insurance/Billing ☐ Legal ☐ Personal
☐ Employment, including for purposes related to the initial referral to EAP/CCP ☐ Other: _____

Disclosure Format and Delivery Method:

☐ Encrypted Email: _____ ☐ Paper ☐ Fax
☐ Mail ☐ Telephone ☐ Other: _____
☐ I will pick up at Best Care EAP/Methodist CCP main office

By signing this Authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I have the right to revoke this authorization at any time, except when Best Care EAP or Methodist CCP has already acted in reliance on my authorization. Revocation must be made in writing to the identified program: Best Care EAP or Methodist CCP, 9239 W Center Road, Suite 201, Omaha, NE 68124.
- Unless otherwise revoked, this authorization remains valid until its expiration date or event, but not greater than one (1) year. Event Date: _____
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
- Information disclosed may contain information about alcohol/drug use, mental/behavioral health, sexually transmitted diseases, AIDS, HIV, or self-paid services.

Prohibition on Re-Disclosure of Substance Use Disorder Records: Substance Use Disorder records are protected by Federal law. 42 CFR Part 2 prohibits unauthorized disclosure of these records. Upon my request, I have the right to receive a list of entities that have received my substance use disorder information.

_____ _____
Client or Authorized Representative Signature Printed Name

_____ _____
Date Relationship to Client (if applicable)

Please allow a minimum of three business days to process after the request is received.

PERMANENT PART OF MEDICAL RECORD
RELEASEOFINFO
Rev. 12/2024