Authorization for Disclosure of Confidential Health Information
FirstCall Employee Assistance Program

I hereby authorize FIRSTCALL Employee Assistance Program (FIRSTCALL EAP) and/or _____ (name of counselor) to release confidential health information from the records of:

Client Name:_____ DOB: _____

Covering the period(s) of care (list applicable dates of assessment/treatment): _____

The purpose of this disclosure of confidential health information is to provide feedback regarding my participation in the Employee Assistance Program and/or _____ (state other purpose(s) of disclosure, if applicable).

Information to be disclosed (check all applicable items to be released):

☐ counselor assessment(s) ☐ attendance at EAP sessions
☐ counselor recommendations ☐ compliance with recommendations
☐ progress in treatment within/beyond EAP ☐ other: _____

This information is to be disclosed to:
Name of Person/Organization:_____
Address:_____
City/State/Zip Code:_____ Phone # (for questions)_____

I understand that FirstCall may deny this request under limited circumstances as provided for under state or federal regulations governing the protection of personally identifiable health information. I further understand that except as otherwise permitted under applicable federal law, I have the right to have a denial of my request reviewed by a licensed health care professional selected by FirstCall EAP who did not participate in the decision to deny my request.

I understand that FirstCall EAP will notify me of its decision to approve or deny my request to access or obtain a copy of the requested information within (30) days of receiving this request if the information is maintained or accessible on-site or within sixty (60) days if the requested information is not maintained on-site. If FirstCall EAP is unable to comply with my request within the specified timeframes, it may extend the applicable deadline for up to thirty (30) days by notifying me in writing.

I understand that this authorization may be revoked in writing at any time, except to the extent that action has already been taken to comply with this request. This authorization will automatically expire in twelve (12) months unless otherwise revoked or indicated to expire on _____ (date not to exceed six months).

_____
Name of client (please print)

_____ _____
Signature of client/authorized representative Date

_____ _____
Signature of witness Date

Employer:_____

NOTICE TO RECIPIENT OF THIS INFORMATION: If the information disclosed to you relates to substance abuse treatment, this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom the information pertains or as otherwise permitted by 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.

Fax to 484-337-4293