AUTHORIZATION TO DISCLOSE INFORMATION FOR FORMAL OR MANDATORY REFERRALS TO THE EAP

By completing this form you allow Beacon Health Options, Inc. to disclose information to the individuals you identify regarding your compliance and/or noncompliance with a formal or mandatory referral to the EAP from your employer.

SECTION 1: Identify the person whose information is to be released:

Name _____ Employed by _____

Member ID# or SSN#_____ DOB____/____/_____ Phone Number_____

SECTION 2: Identify the person or entity who is to receive the information:

Print the Name(s) of person receiving records:

_____

_____

_____

SECTION 3: Identify what information may be released:

☐ Whether or not the employee contacted EAP, including dates of contact;

☐ Participation or non-participation in the EAP-recommended plan of action;

☐ Other: _____

By initialing the following items, you are authorizing Beacon Health Options, Inc. to release the following specific types of information to the person(s) identified in Section 2 above:

____ Alcohol or substance use information and/or records

____ Mental health information and/or records

____ HIV/AIDS related information and/or records

SECTION 4: Identify how long you would like this authorization to last:

This authorization shall be in force and effect for one year or until revoked by the undersigned, in the manner described below or until (insert expiration date or event) _____ (whichever is shorter).

SECTION 5: Your Rights:

You have a right to request a copy of this form and to request a copy of the information that is being disclosed. You do not have to sign this authorization and your refusal will not affect your benefits unless this authorization is necessary to determine your benefits. You have a right to revoke this authorization at any time by sending written notice to:

Beacon Health Options, Inc.
[Operations/Service Center street address]
[Operations/Service Center City, State, ZIP]

Revoking this authorization will not have any effect on actions that Beacon Health Options, Inc. takes prior to receiving the notice of revocation. The information disclosed by this authorization may be at risk for re-disclosure by the recipient and no longer protected by federal privacy laws. Please note that if you have authorized the release of ONLY alcohol or substance abuse treatment records, you may revoke this authorization verbally. Revocation involving all other types of health care records must be in writing.

_____ _____

Signature of the Individual Date

_____

Print Name

INSTRUCTIONS FOR AUTHORIZATION COMPLETION

1. Please PRINT information in pen so it is easy to read.
2. Do not skip any steps. Fill all information in as completely as possible.
3. Following are examples of information that may be listed in Section 3 next to the "Other" box:
   - Results of drug and/or alcohol screens
   - Treatment plan
   - Aftercare plan
   - Specific information regarding noncompliance (e.g., nonattendance at aftercare meetings, missed appointments with treating provider, etc.)
4. **You must initial the item regarding alcohol or substance use information and/or records in Section 3 and provide your signature, your printed name and the date in Section 5.**

QUESTIONS: Call your EAP Workplace Consultant if you have any questions or concerns regarding this authorization form.