Authorization for Release of Protected Health Information

I, _____, DOB:_____ authorize the use and disclosure of protected health information as described below:

- ☐ **A mutual release and sharing of information BETWEEN the individual/organization listed below and Employee Assistance of the Pacific**
- ☐ **Release of information TO the individual/organization listed below from Employee Assistance of the Pacific**
- ☐ **Request of information FROM the individual/organization listed below to Employee Assistance of the Pacific**

Name and/or Organization: _____

Address:_____ City/State/Zip:_____

Phone:_____ Email:_____

The reason why this information should be released is:

☐ At my request ☐ Determine need and type of treatment/education

☐ Attendance and participation with EAP, EAP recommendations, and compliance with recommendations

☐ Care coordination/management ☐ Other_____

This authorization includes the release of the following:

- ☐ Diagnosis and/or treatment for alcohol use or dependency and/or drug abuse or dependency
- ☐ Diagnosis and/or treatment of mental illness
- ☐ HIV antibody test results and/or AIDS diagnosis and treatment
- ☐ Genetic testing information
- ☐ _____

This authorization shall be in force and effect for **1 year** or until I revoke it in writing, or until _____, whichever is shorter.

(insert expiration date or event)

By my signature below, I understand my rights:

- I understand that my records are protected under Federal and State confidentiality laws and regulations and may not be disclosed without my written consent unless otherwise provided for in the regulations.
- "Employee Assistance of the Pacific" includes its staff, affiliate providers, and consultation vendors.
- I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.
- I have a right to request a copy of this form and to request a copy of the information that is being disclosed.
- This release is voluntary and I do not have to sign this authorization.
- Information may be released in written, verbal, and/or electronic format.
- I understand that if the information authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations. I have the right to seek assurances from such recipient of my information that they will not redisclose the information to any other party without my further authorization. Employee Assistance of the Pacific will not be held liable for any redisclosure of protected health information by such recipient.
- I acknowledge that this information to be released was fully explained to me and this consent is given of my own free will.

Date: _____ Signature: _____ Phone: _____

If signed by other than patient or parent of minor child, please print name and indicate relationship. Submit documents to show authority to request information on this individual.

Print: _____ _____

Authorized representative's name *Relationship to Client*

FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2:

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.