

MANAGEMENT REFERRAL FORM /AUTHORIZATION FOR RELEASE OF INFORMATION

To initiate a Management Referral please: First call 1-800-243-5240 for the initial consultation. Then, after meeting with the employee and having them sign this form, immediately fax it to the Consultant named below at 888 892-8832.

MANAGEMENT INFORMATION:

Referring Company: _____ Referring Person: _____
Title: _____ Telephone: _____ Email address: _____

EMPLOYEE INFORMATION:

Name: _____ DOB: _____ Position: _____

Telephones: Work: _____ Home: _____

Cell: _____ Insurance Information: _____

Department: _____ Does employee work in a safety sensitive position? Yes No

Type of referral being made:

Mandatory Referral (there are job consequences for not following through with the EAP referral)

Deadline by which employee must call the EAP for an appointment: _____

Reason for Referral (complete or attach documentation describing reason/job performance issues):

Expected changes as a result of referral:

To the Employee: By signing this form, you are authorizing the EAP to release the following information to the below listed company representatives:

The following company representatives have the right to receive information from the EAP

Name: _____ Title: _____ Telephone: _____ Email: _____

Name: _____ Title: _____ Telephone: _____ Email: _____

Name: _____ Title: _____ Telephone: _____ Email: _____

This release of information expires on the following date: _____

If the expiration date is not specified, this authorization is for continuing disclosure valid for 365 days after the date of the employee/member signature.

Information to be released

Attendance and compliance (or failure to attend and comply) with all provider recommended treatment

By checking this box I agree the information above may be transmitted by email

This release of information covers the following dates: Date from _____ Date through _____

EMPLOYEE PRIVACY/HIPAA INFORMATION:

- You may revoke this Authorization at any time by submitting a written revocation to your EAP at 10260 Meanley Drive, Second Floor, San Diego, CA 92131
- A revocation will not apply to information that has already been used or disclosed in reliance on this Authorization.
- Once information is disclosed pursuant to this Authorization, it may be re-disclosed by the recipient and the information may no longer be protected by HIPAA.
- The plan may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this Authorization.
- You will be provided with a copy of this Authorization form upon completion and execution.

Signature of Employee

Date

Signature of Witness

Date

FAX COMPLETED DOCUMENT TO: _____
(Consultant name)

(Fax number)

Consultant contact information: _____
(Telephone number)

(Email address)

NOTICE TO RECIPIENT(S) OF INFORMATION: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). Information disclosed to you pertaining to certain conditions, such as treatment for alcohol or drug abuse, HIV/AIDS and other sexually transmitted diseases, behavioral health, and genetic marker information is protected by various federal and state laws that prohibit any further disclosure of this information by you without the express written consent of the person to whom it pertains or as otherwise permitted by such laws. Any unauthorized further disclosure in violation of state or Federal law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient consent for release of these types of information. Federal rule 42 CFR Part 2 restricts use of the information disclosed to criminally investigate or prosecute any alcohol or drug abuse patient.