EFR EMPLOYEE & FAMILY RESOURCES

AUTHORIZATION TO DISCLOSE/OBTAIN CONFIDENTIAL INFORMATION

I, _____ (Employee/ Student Name), _____ (Date of Birth), authorize Employee & Family Resources (EFR) to

☐ Disclose ☐ Obtain ☐ Disclose and Obtain, written and verbal communication to/from the entity identified below:

_____
Employer/ School Contact Person Name (if applicable)

_____ _____
Employer/ School Name Phone, Fax, or Email Address

Description of Information to be disclosed/obtained (please initial next to each item to be disclosed/obtained):

_____ Attendance or non attendance at Employee & Family Resources appointments
_____ Agreement/Disagreement with recommended referral(s)
_____ Follow-through or non follow-through with referral recommendation
_____ Assessment/Summary of findings
_____ Discharge/Treatment summary
_____ Other (specify):_____

For the purpose of: _____

Expiration: This authorization will terminate upon the date that is twelve months from the date of this authorization.

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying EFR in writing at the address provided on this form; the revocation will not apply to any information already released by EFR before receiving the revocation.
- Signing this authorization is not a condition for my treatment or payment of my treatment; potential consequences for my refusal to sign this authorization, if applicable were explained to be: _____
- There is the potential that the protected health information (PHI) disclosed by EFR per this authorization may be redisclosed by the recipient and the PHI will no longer be protected by the HIPAA privacy regulations or 42CFR, Part 2 unless the recipient of the information is also obligated to and compliant with HIPAA and 42CFR, Part 2.

_____ _____
Signature of Client Date

_____ _____
Name and Signature of Person authorized to sign in lieu of client, if applicable Date

Explanation of representative's authority to act for the client: _____

NOTICE OF REDISCLOSURE

To the extent substance abuse information has been released pursuant to this authorization, a copy of this authorization will accompany the disclosure and the recipient should note the following obligations: **42 CFR Part 2 prohibits unauthorized use or disclosure of these records.** This authorization permitted information to be disclosed to you from records protected by state and federal confidentiality rules. Federal law (42 CFR Part 2) prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law. 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 client.