

## INTEGRATED BEHAVIORAL HEALTH

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### AUTHORIZATION TO RELEASE EAP, MENTAL HEALTH, DRUG OR ALCOHOL ABUSE INFORMATION FOR MANDATORY EMPLOYEE EVALUATION OR TREATMENT

**Authorization:** I authorize the health care providers, including, without limitation, IBH EAP Counselors (both corporate and community-based EAP counselors), evaluating and treating physicians, psychotherapists, drug and alcohol counselors, hospitals and pharmacists) who have rendered EAP, mental health, drug, or alcohol abuse evaluation or treatment on my behalf, to release my medical records, recommendations and verbal or written reports (the "Records") pertaining to my evaluation or treatment to Integrated Behavioral Health (IBH), and/or to \_\_\_\_\_, a representative ("Representative") of my employer, \_\_\_\_\_. I authorize IBH to release Records received from the EAP and health care providers to the Representative. I also authorize the Representative to discuss information obtained through this release with my supervisor(s) or human resource personnel at my employer to facilitate my return to work, if appropriate. I further authorize IBH to consult with EAP Counselors and/or healthcare providers and to release any information IBH may have that facilitates this evaluation and or treatment.

**Confidentiality:** I understand that these records may be protected as confidential under state and federal laws and federal regulations, including 42 CFR Part 2, and may include a history of drug or alcohol abuse, mental health treatment, or testing or treatment for Acquired Immune Deficiency Syndrome ("AIDS"). IBH, the employer and the Representative, agree that this information will not be re-disclosed to other parties, except as stated in this release, without your expressed written consent.

**Purposes:** I understand that IBH and the Employer will use the records and reports for the following purpose:

1. to evaluate my ability to return to work and/or perform my job safely and efficiently,
2. to monitor the efficacy of the behavioral health programs,
3. and/or for the other purpose, if any, described below;

**Revocation:** I further understand that this consent is subject to revocation at any time if I give written notice to the above designated representative. If this authorization is revoked, the revocation will not affect action that has been taken based on this authorization while effective. If not revoked, this consent will terminate two years from the signing of this agreement.

**Release:** By signing this authorization to release Records, I release IBH, my employer, its officer, agents, directors, employees, and assigns, and the Representative from Liability based on breach of the privilege of physician/patient confidentiality.

I authorize copies of this release to be used as if they were an original.

\_\_\_\_\_  
*Signature of Patient or Legally Authorized Representative*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Printed Name*

\_\_\_\_\_  
*Witness*

\_\_\_\_\_  
*Date*

#### NOTICE

THIS INFORMATION HAS BEEN DISCLOSED FROM CONFIDENTIAL RECORDS PROTECTED BY FEDERAL LAW. FEDERAL REGULATIONS (42 CFR PART 2) PROHIBIT ANY FURTHER DISCLOSURE OF THIS CONFIDENTIAL INFORMATION 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.