



## Authorization for Use or Disclosure of Medical Information

### Read this information first:

Completion of this document authorizes the disclosure and/or use of protected health information, as set forth below, consistent with state and federal laws regarding the privacy of such information. This authorization will remain in effect until the (a) all follow-up associated with such referral; (b) one (1) year from date signed; or (c) the date you withdraw your permission.

### Step 1: Complete the demographic information for the person receiving services:

- |                              |                          |
|------------------------------|--------------------------|
| 1. _____                     | 2. ____ / ____ / _____   |
| <b>Member Name</b>           | <b>Date of Birth</b>     |
| 3. _____                     | 4. (____) _____ - _____  |
| <b>Address</b>               | <b>Home Phone Number</b> |
| 5. _____                     | 6. ____ - ____ - _____   |
| <b>Name of Policy Holder</b> | <b>Policy Holder SS#</b> |

7. Employed by: \_\_\_\_\_

8. Persons/Organizations authorized to use or disclose the information: ValueOptions Employee Assistance Program (EAP) and Contracted Counselors

9. Persons/Organizations authorized to receive the information:

10. Purpose of requested use or disclosure: Compliance and/or non-compliance with referral by employer related to violation of Department of Transportation (DOT) drug and alcohol regulations

### Step 2: This authorization applies to only the following records, including dates:

- Contact(s) with EAP;
- Participation or non-participation in recommended plan of action;
- Continuation or discontinuation in recommended plan of action; and/or
- Other: \_\_\_\_\_

**Step 3: Sign acknowledgement of Federally Regulated Laws:**

I understand that, because I was referred to the Substance Abuse Professional following a DOT violation, the Substance Abuse Professional is required by federal law to notify the Designated Employer Representative of my name, diagnosis, treatment plan and compliance with recommendations for treatment or education. Restrictions on re-disclosure do not apply to these federally mandated disclosures.

11. \_\_\_\_\_  
**Employee signature**

\_\_\_\_\_  
**Date and Time**

**Step 4: Complete your acknowledgement that You understand that:**

- You have the right to review the information that is being used or disclosed;
- Refusal to complete this authorization will not effect treatment, payment, enrollment or eligibility for benefits;
- The information used or disclosed by this authorization may be at risk for re-disclosure by the recipient and no longer protected by federal privacy laws;
- You have a right to revoke this authorization at any time by completing and sending to ValueOptions a “Revocation of Authorization” Form, which may be delivered to:  
 \_\_\_\_\_
- Your revocation will be effective immediately upon receipt by ValueOptions, but will not affect actions taken on the basis of this Authorization;
- You have a right to receive a copy of this signed authorization.

12. \_\_\_\_\_  
**Employee signature**

\_\_\_\_\_  
**Date and Time**

**Step 5: Sign acknowledgement of Drug and/or Alcohol Records:**

I acknowledge that information to be used or disclosed as a result of this Authorization may include records that are protected by federal and/or state laws. I SPECIFICALLY AUTHORIZE THE RELEASE OF CONFIDENTIAL INFORMATION RELATING TO DRUG AND/OR ALCOHOL ABUSE. The recipient of drug and/or alcohol information disclosed as a result of this Authorization will need further written authorization to re-disclose this information. 42 CFR §2.32 restricts any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.

13. \_\_\_\_\_  
**Employee signature**

\_\_\_\_\_  
**Date and Time**



## INSTRUCTIONS FOR AUTHORIZATION COMPLETION

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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. Step 2: The following are examples of what may be filled in where the form says “Only the following records or types of health information”: Other:
  - 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 sign and date #11, #12 and #13.

**QUESTIONS: Call your EAP Care Manager if you have any questions or concerns regarding this authorization form.**