

# Authorization for Use and Disclosure of Protected Health Information



I hereby authorize Evernorth® (EAP), its agents, subsidiaries or affiliates to disclose the below-referenced information to the person(s) or entity specified on this form.

## Employee/Customer Information:

**Identification of person authorizing release: (Please fully and accurately complete all applicable items.)**

Name of Employee/Customer whose information shall be disclosed:

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Employee's Social Security Number: (Optional): \_\_\_\_\_

Employer Name: \_\_\_\_\_

## Entity (i.e., Employer) or Person(s) Authorized to Receive Information:

Name of Entity/Employer Representative: \_\_\_\_\_

Title and Department: \_\_\_\_\_

Entity/Employer Name: \_\_\_\_\_ Phone number: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Name of Entity/Employer Representative: \_\_\_\_\_

Title and Department: \_\_\_\_\_

Entity/Employer Name: \_\_\_\_\_ Phone number: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Name of Entity/Employer Representative: \_\_\_\_\_

Title and Department: \_\_\_\_\_

Entity/Employer Name: \_\_\_\_\_ Phone number: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

## Description of Information to be Used or Disclosed:

- 1) Attendance or Non-Attendance at EAP session(s). Disclosure will not include diagnostic and/or clinical information.
- 2) Suggestions, if any, resulting from the EAP assessment regarding workplace/supervisory strategy that may support improved work performance. Disclosure will not include diagnostic and/or clinical information.
- 3) Recommendation(s), if any, resulting from the EAP assessment. Information shall be limited to identifying the **level of care:** (outpatient, partial hospitalization, inpatient or residential); **type of referral resource(s):** (self-help, support groups, medical evaluation, etc.); and the **name of the treating provider and/or facility if requested for purposes of ongoing follow-up.** Disclosure will not include diagnostic and/or clinical information.
- 4) The estimated time frame necessary to complete the recommendation(s). Information will not include diagnostic or clinical disclosure.
- 5) The employee's demonstrated compliance or non-compliance with initial follow-through on the recommendation(s). Disclosure will not include diagnostic and/or clinical information.

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# Authorization for Use and Disclosure of Protected Health Information (Continued)

## Purpose of Use or Disclosure:

To confirm the employee's compliance with the process for formal management or continuation of employment referrals to the EAP and to assist in restoring optimal job performance.

## Expiration of Authorization:

**This document shall expire 60 days following discharge from and/or completion of treatment or education as recommended by the EAP provider**

## Your Rights:

- You may revoke this authorization at any time by sending a written request to Evernorth EAP, 6625 W 78th Street, Ste. 100, Bloomington, MN 55439.
- You may request a form to revoke the authorization by calling Evernorth at: 1.800.433.5768, ext. 2350. If you submit a request to revoke this authorization, it will not apply to information disclosed prior to the receipt of the revocation request, pursuant to your signed authorization.
- You may refuse to sign this authorization form. The provision of treatment, payment, enrollment or eligibility for benefits does not depend on whether you sign this authorization.
- You have a right to request a copy of this authorization form and to request a copy of the information disclosed pursuant to your signed authorization.
- Information disclosed as a result of this authorization may be subject to re-disclosure by the recipient and no longer protected by law. However, pursuant to 42 CFR 2.32, the recipient of drug and/or alcohol abuse information disclosed as a result of this authorization will need your further written authorization to re-disclose this information to a third party and is restricted from using this information to criminally investigate and/or prosecute a drug and/or alcohol abuse patient. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

*I understand that if information on this form is not complete, Evernorth will return the form to me, and this request will not be considered until Evernorth has received all the required information.*

## SIGNATURE

**I have read and understand the above information.** Signature of employee/customer or personal representative authorizing the use and disclosure of the information described.



\_\_\_\_\_

Date: \_\_\_\_\_

Relationship, if person signing is other than Participant: \_\_\_\_\_

*If this request is made by a Parent/Guardian, complete the following: Participant is a minor, \_\_\_\_ years of age.*

*If you are making this request on behalf of a minor child, we may require additional information before this request is considered complete.*

*If not already provided, we will require verification of the authority of a Personal Representative before this request will be considered complete.*

## Please Return This Completed Form To:

### Evernorth

Department Name: Employee Assistance Program

**Department Address:** 6625 W 78<sup>th</sup> Street, Ste. 100

Bloomington, MN 55439

Department Secure Fax: 860-687-7261

Employee Assistance Consultant: \_\_\_\_\_

**Telephone Number: 888-244-6293 ext.** \_\_\_\_\_

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