AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION TO THE WORKPLACE

Client Name: ____ **Date of Birth**: ____/____/________

I hereby authorize the exchange of Protected Health Information between:

The Insight Program AND	Name: ____
	Office: ____
7501 O Street Suite 100	Address: _______________________________________
Lincoln, NE 68510	City: ______________________________ State: _______
Phone: (402) 477-0651	Phone: (_____) _____-__________
Fax (402) 477-0332	Fax:(_____) _____-___________

Information to be exchanged:

□ Current Status (compliant/non-compliant) □ Attendance Records □ Expected Length of Treatment □ Information Regarding Referral Issue □ Other ______________________________

Reason for Disclosure:

☐ To verify my EAP participation and compliance with treatment recommendations of Insight EAP, as required by my employer as a condition of my employment (***Mandatory Performance Referral***)

☐ Other (*specify*) ____

The validity of this release will extend for a period of one year from the signature date. An electronic or faxed copy of this authorization is valid.

Clients may revoke an authorization to release information at any time by sending written notification. I understand that a revocation is not effective to the extent that the providing organization has relied on the authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

____ Date: ____/____/________ **Client Signature/Parent (if Minor)/Guardian**

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Printed Name