



Authorization B

Authorization to Obtain Confidential Information

I, _____, hereby authorize

(name of organization and/or individual)

to disclose verbal or written information regarding the following (each applicable line will be checked):

- _____ Treatment Recommendation
- _____ Attendance/follow-through or non follow-through with treatment services
- _____ Discharge/Treatment summary
- _____ Other (specify) _____

To: Employee & Family Resources
505 Fifth Avenue, Suite 600
Des Moines, Iowa 50309

Telephone: (515) 244-6090
(800) 327-4692

For the purpose of:

- _____ Assisting in EFR Assessment/Referral
- _____ Monitoring follow through with referral
- _____ Case Management to monitor progress
- _____ Other _____

This authorization is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this authorization will terminate upon the earlier of twelve months from the date of this authorization, or

(if applicable, state specific date, event, or condition)

I have been provided a copy of this form.

Signature of Client

Date

Signature of Parent or Guardian (Where Required)

Date

Signature of Person authorized to sign in lieu of the client

Date

PROHIBITION OF REDISCLOSURE

This form does not authorize redisclosure of medical information beyond the limits of this authorization. Where information has been disclosed from records protected by federal law or alcohol/drug abuse records or by state law for mental health records, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa Code ch.22B) prohibit further disclosure without the specific written authorization of the patient or as otherwise permitted by such law and/or regulations. A general authorization or the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.