**Authorization to Obtain or Disclose Confidential Information**

**Authorization B**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, DOB \_\_\_\_\_\_\_\_, authorize Employee & Family Resources (EFR) and its provider (if applicable), \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, to:

\_\_\_x\_\_\_ Disclose written and verbal information to the individuals or organizations identified on this form

\_\_\_x\_\_\_ Obtain written and verbal information from the individuals or organizations identified on this form

This information may be obtained from and/or shared with:

To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Organization and Contact Person Name

At: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address and/or City, State Phone Number

To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_OR DESIGNEE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Name and Contact Person Name

At: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address and/or City, State Phone Number

**Description of Information to be Disclosed/Obtained** – **client to initial each item to be disclosed/obtained**.

\_\_\_\_\_ \_x\_ Status of attendance at appointments

\_\_\_\_\_ \_x\_ On-going report of progress and client engagement

\_\_\_\_\_ \_x\_ Formal referral recommendations for specific type and resource

\_\_\_\_\_ N/A Formal referral recommendations for non-specific type or  
 resource

\_\_\_\_\_ \_x\_ Status of employee follow-through with referral   
 recommendations

\_\_\_\_\_ \_x\_ Disclosure of client’s progress on established workplace goals

\_\_\_\_\_ \_x\_ Final progress on established workplace goals

\_\_\_\_\_ \_x\_ Information reported by employer

\_\_\_\_\_ N/A Drug testing results and recommended testing plan

\_\_\_\_\_ \_x\_ Discharge/Transfer Summary

\_\_\_\_\_ \_\_\_Other (specify):

Specific authorization for release of information protected by Federal and State law (client initials required):

\_\_\_\_\_ \_X\_Mental health records \_\_\_\_\_ \_X\_Substance abuse records \_\_\_\_\_ \_\_\_HIV related information

For the purpose of: Provide status updates and other information to employer on my progress with goals and expectations of the employer.

**Expiration:** This authorization will terminate upon the date that is twelve months from the date of this authorization.

I have read and understood the following statements about my rights:

* I may revoke this authorization at any time prior to its expiration date by notifying EFR in writing at the address provided on this form; the revocation will not apply to any information already released by EFR before receiving the revocation
* Signing this authorization is not a condition for my treatment or payment of my treatment; potential consequences for my refusal to sign this authorization, if applicable were explained to be:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
* There is the potential that the protected health information (PHI) disclosed by EFR per this authorization may be redisclosed by the recipient and the PHI will no longer be protected by the HIPAA privacy regulations or 42CFR, Part 2 unless the recipient of the information is also obligated to and compliant with HIPAA and 42CFR, Part 2.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_

Signature of Client Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_**

Name & Signature of Person authorized to sign in lieu of the client, if applicable Date

Explanation of representative’s authority to act for the client\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ \_

I was offered and/or given a copy of this authorization **(Client and/or representative initial)**

**NOTICE OF REDISCLOSURE**

To the extent substance abuse information has been released pursuant to this authorization, a copy of this authorization will accompany the disclosure and the recipient should note the following obligations: This authorization permitted information to be disclosed to you from records protected by state and federal confidentiality rules. Federal law (42 CFR Part 2) prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

Employee & Family Resources, 505 5th Avenue, Suite 600, Des Moines, IA 50309, Fax: (515) 284-5201