AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

I,

Name	Insight EAP Case Number	Date of Birth
Address	City	State & Zip

hereby give permission to The Insight Program, P.C. or any of its subsidiaries or affiliates (Insight EAP) and the Insight EAP staff performing services in connection with my treatment to: either disclose information to each of the following and/or obtain information from each of the following: *(check one or both boxes)*

☐ _____ *and successor or designee of Contact* _____

☐ _____ *and successor or designee of Provider*

PURPOSE OR USE OF 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)*: _____

PHI TO BE USED OR DISCLOSED

Only the following information (client MUST initial each item to be disclosed)

☐ (INITIAL) Current Status (compliant/non-compliant)

☐ (INITIAL) Attendance Records

☐ (INITIAL) Treatment Recommendations

☐ (INITIAL) Diagnosis/Assessment

☐ (INITIAL) Substance Use Evaluation

☐ (INITIAL) Progress Report on My Treatment

☐ (INITIAL) Expected Length of Treatment

☐ (INITIAL) Drug/Alcohol Test Results

☐ (INITIAL) Specify information to be disclosed and any restrictions: _____

EXPIRATION OF AUTHORIZATION

☐ This date *(no more than 1 year from today)*: _____

☐ This date *(90 days from today)*: _____

☐ ___ Months after my EAP case is closed

OVER

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YOUR RIGHTS

- You may end this authorization at any time by writing to The Insight Program, P.C. 7501 'O' Street, Suite 101 Lincoln, NE 68510. If you make a request to terminate this authorization, it will not include information that has already been used or disclosed based upon your previous permission, including Insight EAP's ability to confirm information already disclosed in a legal proceeding. For more information about this and other rights, please refer to the NOTICE OF PRIVACY PRACTICES
- Signing this form does not impact your treatment, payment, enrollment or eligibility with Insight EAP
- You do not have to agree to this request to use or disclose your PROTECTED HEALTH INFORMATION
- You have a right to a copy of this signed authorization.

REDISCLOSURE BY RECIPIENT

Except as described below, information that is disclosed as a result of this AUTHORIZATION FORM may be subject to re-disclosure by the recipient and no longer protected by law. Insight EAP has to follow laws that protect your health information, but not all persons or organizations have to follow these laws.

If you have questions about anything on this form, please clarify with your EA professional BEFORE signing this document.

SIGNATURE

CLIENT SIGNATURE _____ DATE _____

AUTHORIZED REPRESENTATIVE _____ DATE _____

If signed by authorized representative, please describe your authority to act for the client: _____

_____

Staff Name *(please print)*: _____ Title: _____

Signature: _____ Date: _____

Notice to Recipient of Information

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records *(42 CFR Part 2)*, you are prohibited 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 42 CFR Part 2. 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 patient.