Authorization for Release of Confidential Information
Formal and Mandatory Referrals

I, _____ (date of birth ___/___/___), hereby authorize Uprise Health, to disclose to my Employer,
Employee First and Last Name

_____, the following information related to a form referral:
Name of Employer

**check boxes to give consent*

- ☐ Confirmation of contact with EAP
- ☐ Attendance at EAP evaluation(s)
- ☐ Summary of treatment recommendations
- ☐ NON-Substance Abuse Professional Program (SAP)
- ☐ Compliance with treatment recommendations, including reports of participation and progress.
- ☐ Substance Abuse Professional Program (SAP)

Contact(s) that I authorize information to be released to are:

Employer Contact_____Phone:_____Fax:_____
Union Contact:_____Phone:_____Fax:_____
Other Contact_____Uprise Health Representative_____Phone:_____Fax: (443) 583-4830

I authorize **Uprise Health** to exchange the following information with **any treatment providers** to which I am referred:

- Reason for referral
- EAP evaluation findings and recommendations
- Results of drug/alcohol tests

Purpose(s) or need(s) for release:

- To allow for communication of compliance with EAP recommendations
- To coordinate care between EAP and any providers to which employee is referred

I understand that individually identified health information ("IIHI") is protected under Federal and/or State confidentiality law. I further acknowledge that the information to be released was fully explained to me and this authorization is given of my own free will. I may withdraw this authorization to disclose IIHI at any time by written revocation except to the extent that the program or person that is to make this disclosure has acted in reliance on it. Upon revocation of this authorization, further release of IIHI authorized by this shall cease immediately. If not previously revoked, this authorization will terminate **one (1) year** from the date written on this form. A file copy is considered equivalent to the original.

I understand that if the organization authorized to receive the information is not a health plan or health care provider, or a contractor thereof, the released IIHI may no longer be protected by federal privacy regulations. I understand that my health care and payment for my health care will not be affected if I do not sign this form. I understand that Uprise Health will not receive financial or in-kind compensation in exchange for using or disclosing the IIHI described above.

_____ _____
Signature of Client Date

Witness: _____

The person signing this authorization is entitled to a copy.

TO THE RECIPIENT OF CONFIDENTIAL INFORMATION: PROHIBITION ON REDISCLOSURE. If the information disclosed to you relates to alcohol and other substance abuse treatment, this information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit 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 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 other substance abuse patient.

NOTE: Please FAX signed/completed form to Uprise Health at 443-583-4830