Authorization for Release of Confidential Information

Formal and Mandatory Referrals

You have been referred by your employer to the KEPRO Acquisitions, Inc. (hereafter referred to as "KAI") Employee Assistance Program out of concern for your job performance and/or policy violation. KAI is a confidential program designed to assist employees by offering an in-depth assessment to determine additional factors that have been contributing to the concern in performance. Recommendations to address these concerns will be made and your compliance monitored. Along with your manager, union representative, and/or HR representative, this team approach requires certain communications relative to your cooperation with the program and is outlined below. No other information, unless authorized by you and indicated on this form, is permissible for disclosure. You signature below indicates your authorization of such communication.

I, _____ (date of birth ____/____/____), hereby authorize KAI to disclose to my Employer, _____, the following information (*please check boxes):

Name of Employer

☐ Confirmation of contact and appointment verification with EAP and its affiliates.
☐ Compliance with treatment recommendations,
☐ Other: __Treatment Plan_____

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

Primary Contact:_____ Phone: (____) ____-_____ Fax: (____) ____-_____
Contact:_____ Phone: (____) ____-_____ Fax: (____) ____-_____
Contact:_____ Phone: (____) ____-_____ Fax: (____) ____-_____

I authorize **KAI** to disclose the following to **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 KAI will not receive financial or in-kind compensation in exchange for using or disclosing the IIHI described above.

_____ _____
Signature of Client Date Signed

_____ _____
Signature of Parent, Guardian or Authorized Representative, (if required, and relationship) Date Signed

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.

PLEASE CONSULT WITH A MEMBER OF THE MANAGEMENT SERVICES TEAM ABOUT THE REFERRAL AT 800-765-0770, OPTION 1 THEN 3, BEFORE **FAXING TO 800-844-2852.**