



AUTHORIZATION FOR DISCLOSURE OF INFORMATION
To Employer for Management Referrals Only

I hereby authorize Optum to disclose the following limited information to my employer _____, in connection with my employer’s management referral: This authorization is limited to the disclosure of the following information:

- A. Confirmation that I have either contacted or not contacted the Optum Employee Assistance Program to access services.
- B. If I have accessed the Optum Employee Assistance Program services, information concerning:
 - 1. Whether or not I have attended all recommended program sessions.
 - 2. Whether or not I have followed all counseling and treatment recommendations.
 - 3. Specific dates of attendance can be reported if requested.

The purpose of this release is: **Management Referral**

I authorize Optum to provide this limited information to:

Name (HR/Manager/Supervisor): _____

Title/Role: _____

Phone Number: _____

I understand that without this authorization, my employer does not have access to any of the confidential information listed above. I understand that I may revoke this authorization, in writing, at any time, except to the extent that action has already been taken based on the release, and that this authorization shall automatically terminate one (1) year from the date of signature, unless earlier revoked by me or if individual state law identifies a specific date limitation.

Confidentiality of alcohol and drug abuse patient records is protected under federal law. Federal regulations (42 CFR, part 2) prohibit anyone from making any further disclosure of the information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

Note: For employees who request their information /EAP file

I understand that if I sign a separate release requesting my EAP file in its entirety, it may include information I provided regarding my mental health, substance use or dependency, or sexuality, and may also contain confidential HIV/AIDS related information. Optum is not responsible for information that employees release directly to their employer. I also understand that my health plan may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this form, except for certain eligibility or enrollment determinations prior to my enrollment in its health plan, and for health care that is solely for the purpose of creating protected health information for disclosure to a third party.

I further understand that I have a right to receive a copy of this authorization upon my request. Copy requested and received: Yes No Initial _____

Signature: _____ **Date:** _____

Print Name: _____ **Date of Birth** _____

Address: _____

Member ID # (optional) _____

(Required for the state of Illinois residents):

Witness Signature _____ **Date:** _____

Print Witness Name: _____