BHS Consent/Authorization to Release/ Obtain Client Information

I _____________________________, hereby consent and authorize ________________________

or designee, of *Business Health Services, 711 West 40th Street, Suite 207, Baltimore, MD 21211* to:

☐ **Release to:** ☐ **Obtain from:**

____

Name of individual, institution

____

Address (city/state/zip) *Telephone Number*

The following types of information:

- ❑ Assessment/Summary
- ❑ Provisional Diagnosis
- ❑ Work Performance
- ❑ Recommendations
- ❑ Safety Assessment/Safety Plan
- ❑ Discharge Summary
- ☐ Routine Supervisory Referral Feedback which includes:
  - Whether I have kept initial or subsequent appointments
  - My compliance with, progress toward fulfillment of, and/or completion of the EAP's recommendations
  - If possible, when the referring supervisor may expect to see an improvement in job performance
- ☐ Other: ____

For the following purposes:

- ❑ Coordination of care
- ❑ Contact with referring supervisor
- ❑ Safety planning
- ❑ Other____

I understand this consent becomes effective on the date I sign it, and will continue in effect for twelve (12) months from that date unless I revoke it before that time. I understand I have the right to revoke this authorization by following the revocation procedures described in the Notice of Privacy Practices. I understand that I am entitled to receive a copy of this authorization upon request. I agree that a photocopy or facsimile copy of this signed authorization form is as valid as an original signed copy. I understand that after this information is disclosed, federal law might not protect it, and the recipient might re-disclose it. I agree to release the above named individual(s) or organization(s) and the EAP, the EAP counselor, and his/her designee from liability that may result from furnishing this information as authorized in this disclosure. I have had the opportunity to review and understand the contents of this form. By signing this form, I am confirming that it accurately reflects my wishes. [If you are a Personal Representative signing on behalf of the client, circle which of the following roles warrants you the authority to sign this form: health care Power of Attorney (copy attached); court ordered Conservator or Guardian (copy attached): Parent of unemancipated minor child: other:_______________.]

____ _________________________

Signature of Client/ Personal Representative (circle one) **Date**

____ _________________________

Witness signature **Date**

To recipient of these records:

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulation (42 CFR Pt. 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. 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 the client.