Consent to Release / Obtain Confidential Information

Client Name: DOB: SS#:

In accordance with Federal Regulations 42CFR, Part 2, I hereby authorize:

HealthSpan EAP

2200 Jefferson Avenue

Toledo, OH 43604

To obtain from: To release to:

Name and address of

of individual/organization:

Information to be released:

AS REQUIRED BY SECTION 2:32(2) PROHIBITION OF REDISCLOSURE RULES:

This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit 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.

Purpose of Disclosure: (Check one or more)

\_\_\_\_\_\_Comprehensive Treatment \_\_\_\_\_\_Family Involvement \_\_\_\_\_\_Legal Issues \_\_\_\_\_\_Employer Involvement

\_\_\_\_\_\_Other:

This authorization for release of information will automatically expire ninety (90) days after the date of the authorization unless I expect to continue receiving services beyond ninety (90) days and extend the authorization to a maximum of one hundred and eighty (180) days. Expiration date is: .

Condition, date or event of earlier/later expiration:

Name and signature of staff facilitating this request:

I understand that this release can be revoked by me at any time and that the revocation must be signed and dated by me. Upon revocation of consent, further release of information shall cease immediately.

Date Signature

Witness Relationship

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I hereby revoke my consent for the release of the above information.

Date Signature

Witness Relationship