Authorization to Use or Disclose Protected Health Information

This form authorizes the use or release of information in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Name: ____________________ Date of Birth: ____________________

Address: ____________________ SSN#: (Last 4 Digits Only) ____________________

____________________ Telephone: ____________________

I authorize Behavioral Health Connecticut, LLC d/b/a Solutions Employee Assistance Program (EAP) to ☐ OBTAIN and/or ☐ DISCLOSE confidential information about me from/to:

Person: ____________________ Address ____________________

Organization: ____________________ ____________________

Phone: ____________________ Fax Number: ____________________

I understand that the records to be disclosed pursuant to this authorization may contain confidential information pertaining to Medical, Psychiatric, Substance Use, HIV/AIDS/STD-related diagnoses, services, service dates, service providers, involvement with state agencies, law enforcement or judicial system, and claims payment information, unless otherwise restricted:

Do NOT Release Information Regarding: ____________________

I authorize the following information to be disclosed. Check all that apply:

☐ Attendance Only
☐ Attendance, Treatment/Counseling Recommendations and Compliance/Progress with Recommendations
☐ All Available Information
☐ Other (please specify): ____________________

Information to be disclosed covers the time period: --

Purpose of Use/Disclosure:
☐ Communication with Employer on Counseling/Workplace Issues
☐ Care Coordination
☐ Entitlements/ Benefits
☐ Monitoring of counseling or treatment progress following referral by Solutions EAP
☐ Job Application
☐ Legal Investigation/Action
☐ Other: ____________________

I understand that this authorization is voluntary. My refusal to sign this authorization will not affect my right to obtain services from Solutions Employee Assistance Program except where such use or disclosure is necessary to provide services to me. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws; provided that the confidentiality of mental health, substance abuse and HIV/AIDS records are protected under State and Federal Laws and cannot be further disclosed without my written authorization unless otherwise provided for by law. A general release of information is NOT sufficient for this purpose. I understand that I may make a request to inspect and/or copy the information to be used and that Solutions EAP will provide me with a copy of this signed authorization.

____

Signature of Individual or Legal Representative

____

Print Name **Date**

If this form has not been signed by the individual, please state signer's authority and provide a copy of legal appointment.

☐ Attorney ☐ Parent/Guardian ☐ Conservator ☐ Estate Executor
☐ Other:

This authorization will expire on: ______/______/______,

or with event: ____________________ ,

but no later than 12 months from today.

I can revoke this authorization at any time, except to the extent that action has been taken in reliance on it, by writing to Solutions EAP or by signing the Cancellation/ Revocation below:

Signature: ____________________
Print Name: ____________________
Date Signed: ____________________

Solutions EAP Hartford Office
151 New Park Avenue, Hartford, CT 06106
Tel: 800-526-3485 | Fax: 203-379-2048

Solutions EAP Meriden Office
816 Broad Street, Suite 27, Meriden, CT 06450
Tel: 800-526-3485 | Fax: 203-379-2048
Statewide Toll-Free Tel: 1-800-526-3485

Solutions EAP Groton Office
21 Chicago Avenue, Groton, CT 06340
Tel: 860-437-2188 | Fax: 860-449-5791