P.O. Box 1827
York, PA 17405-1827
800.673.2514 Tel
717.851.4493 Fax
www.WellSpan.org/EAP

WellSpan
Employee Assistance Program

Authorization to Release EAP Information

I hereby authorize WellSpan EAP to disclose information to:

_____ _____
(Primary Contact Name Phone Number) (Email Address of Primary Contact)

_____ _____
(Secondary Contact Name Phone Number) (Email Address of Secondary Contact)

from the records of: _____
(Employee's Name) (Date of Birth)

_____
(Home Address) (Telephone Number)

Information to be released: By my signature below, I recognize that the information to be released may include my attendance at EAP sessions used in addressing the reason for this referral, and recommendations that may be provided to me or my employer regarding this referral. Attendance at EAP sessions may include scheduled appointment dates and attendance at those sessions, missed appointments, etc. Recommendations may include, but is not limited to, suggestions made by my treatment provider regarding referral for treatment beyond EAP sessions, recommendations for follow-up drug/alcohol testing (if referral was made for substance use/abuse), and suggestions for my employer in assisting me with resolving the issue being addressed by this referral.

This information is being disclosed to the above person(s), organization or agency from records whose confidentiality may be protected by the Drug and Alcohol Abuse Control Act (Pennsylvania Law, Act 63) and/or the Mental Health Procedures Act (Pennsylvania P.L. 817) and/or Confidentiality of Alcohol and Drug Abuse Patient Record Regulations (Federal Public Law 93-282) or, in accordance with the state where you receive services. My signature below authorizes release of all such information by routine/express mail service or facsimile transaction or by phone, confidential email.

I understand that I have no obligation whatsoever to disclose information from my record and understand that I may revoke this authorization at any time in writing, except to the extent that action based on this consent has been taken. I fully understand the contents of this authorization and voluntarily consent to the release of the information as stated. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I may refuse to sign this authorization which is required as part of the supervisory referral process initiated by my employer. My refusal to sign will not affect my eligibility of EAP benefits.

This authorization shall expire one (1) year from the date executed unless otherwise specified by the client (employee).

_____ _____
(Print Employee's full name) (Signature of Employee/Responsible party) (Date)

_____ _____
(Print Primary Contact/Witness full name) (Primary Contact/Witness Signature) (Date)

Company making referral: _____

Note: This authorization will not be accepted unless it is completed in its entirety. A copy of the form will be accepted in lieu of an original.