Release of Information

for the Washington State Employee Assistance Program

(Authorization for Use or Disclosure of Protected Health Information)

I, (*client name*)_____, authorize the Washington State Employee Assistance Program to disclose my information to the following agency, provider, or individual:

_____

Name Position

_____

Telephone Address

The specific purpose of this disclosure is for ☐my work performance, ☐treatment planning, ☐case management, ☐other:_____

_____.

I understand that my records are protected under Federal Regulation 42 CFR, Confidentiality of Alcohol and Drug Abuse and under state (Health Care Information Act) Confidentiality Regulations and cannot be disclosed without written consent, except as a specifically stated by the law.

I understand that, under the law, my records may be released without my consent in accordance with the Notice of Privacy Practices for the Washington State EAP and the Client Statement of Understanding.

This authorization expires in 90 days from the date signed unless I expressly revoke my consent earlier than that date. My consent for disclosure is subject to my express revocation at any time prior to the above condition, event, or date, except to the extent that any action has been taken by EAP in reliance upon my authorization.

_____

Printed name of client

_____

Signature of client Date:

_____

Signature of EAP Representative* Date:

**If not signing in the presence of an EAP Representative, see page 2 for instructions*

In lieu of coming in-person to the EAP office with an ID to receive a copy of the record, a client may sign this form in the presence of a notary. **Note**: The Employee Assistance Program may require additional information to ensure the accuracy of this information provided.

I understand that if I do not complete and return this form, my request will be denied.

You must complete and sign this form in the presence of a notary.

Please Note: Any person who requests or obtains confidential information and records related to mental health services pursuant to this chapter under false pretenses is guilty of a gross misdemeanor (RCW 70.02.330 Obtaining confidential records under false pretenses—Penalty)

I certify under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct and that I am the individual requesting access to inspect or copy my own records.

_____

Client Signature Date

_____

Client Printed Name

_____

Address

To be completed by a Licensed Notary Public:

Name of Notary:_____

Signed or Attested before me on:_____day of_____month of _____year.

_____

Signature of Notary Date My Appointment Expires

Seal or Stamp: