ManagerAssist Line: 1-877-249-4751

Please return this completed and signed form via Email: ManagerConsult@workplaceoptions.com or Fax: 1-866-240-3933

Date of Referral: _____

EMPLOYEE INFORMATION:

Employee Name: _____

Date of Birth: _____ Gender: Male / Female

Address: _____

Cell or Home number: _____ Can a message be left on voicemail? Yes / No

Work number: _____ Can a message be left on voicemail? Yes / No

Email: _____

Employee's position: _____ Department: _____

Current Employment Status (e.g., working, suspended, on leave etc.): _____

COMPANY AND REFERRING MANAGER DETAILS:

Company Name:_____

1-Manager/HR Name:_____

Telephone: _____Email:_____

2-Manager/HR Name:_____

Telephone:_____Email:_____

REASON FOR THE REFERRAL:_____

_____

_____

Signature of Employee: _____

Signature of Manager/HR: _____

Date: _____

Date: _____

Revised May 2015

AUTHORIZATION TO RELEASE/RECEIVE INFORMATION

I, _____, hereby authorize **Deer Oaks**
(Employee Name)

EAP to release / receive information contained in my case records subject to the conditions below.

1. The name of the person(s), title, organization(s) to whom disclosure is to be made is (list each person):

_____
(Authorized Supervisor or HR Representative - Name and Title)

2. The specific information Deer Oaks EAP is authorized to release / receive is*:
   - ✓ Scheduled appointments and attendance
   - ✓ Compliance with EAP session treatment recommendations
   - ✓ Referral to outside resources to address the problem where appropriate
   - ✓ After-care recommendations where appropriate
   - ○ **DOT/SAP:** For referrals that include substance use issues, does the employee fall under the scope of the Federal DOT, and will therefore require a DOT/SAP evaluation?

*(***Manager Referrals are not intended to provide Fitness for Duty or Return to Work performance assessments.***)

3. The purpose of the disclosure I am authorizing is:
   - ✓ To facilitate a referral to Deer Oaks EAP.
   - ✓ To provide feedback regarding my contact and participation with Deer Oaks EAP. This information may include previous contact and participation with Deer Oaks EAP and will terminate automatically one year from the date of the employee signature below.

4. I understand that if the person or agency that receives my information is not a health care provider or health plan covered by the HIPAA privacy regulations, the information described above may be redisclosed and is no longer protected by these regulations.

5. I understand written notification is necessary to cancel this authorization and can be addressed to the department listed at the top of this form. I am aware that my cancellation will not be effective as to disclosures already made in reference to this authorization. I understand Deer Oaks EAP may not condition treatment on my decision to sign this authorization.

6. I understand that this disclosure may include information regarding drug abuse, alcoholism, or alcohol abuse, psychiatric or mental illness, Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV regulated by Federal Statute (42 CFR Part 2).

Employee Name
(Please print): _____

Signature of
Employee: _____

Date: _____

Phone: _____

Email: _____

Referring Manager
Name (Please print): _____

Signature of
Referring Manager: _____

Date: _____

Phone: _____

Email: _____