

HORIZON HEALTH EMPLOYEE ASSISTANCE PROGRAM MANAGEMENT REFERRAL FORM

To initiate a Management Referral, please call 1-800-243-5240. Immediately after the call, fax completed form to 1-888-892-8832
Management Resource Center

MRC: _____

Company Name: _____ Location: _____

Department: _____ Phone: (_____) _____

Referring Party: _____ Title: _____

Client Referred: _____ DOB: _____ / _____ / _____

Client's Phone: Work: (_____) _____ Home: (_____) _____

Client's Insurance: _____ SSN: _____

Reason for Referral (complete or attach documentation describing reason/job performance issues):

Last Chance Agreement: (attach if written) Yes No Deadline Employee Must Call for Appt: _____ / _____ / _____

To the Employee: By signing this form, you are allowing Horizon Health EAP Services to release the following information:

Scope of Release: Alcohol/Drug Evaluation/Treatment Attendance Recommendations/Follow Through Compliance

To the following person(s):

Name Title (_____) Phone

Name Title (_____) Phone

Relation of above person(s) to client: _____

Purpose of releasing information: To track compliance with treatment recommendations
 Other (please specify) _____

This release expires on the following date: _____ / _____ / _____ **1 Year or less per HIPAA**

AUTHORIZATION

This authorization for use or disclosure of information is being authorized by me giving Horizon Health EAP permission to disclose information (checked off above) obtained in the course of assessment. I understand that the information to be released may contain information pertaining to mental health, drug and/or alcohol related evaluation and/or treatment compliance.

Your rights:

- ◆ You may revoke this Authorization at any time by submitting a written revocation to Horizon Health EAP.
- ◆ A revocation will not apply to information that has already been used or disclosed in reliance on this Authorization.
- ◆ Once information is disclosed pursuant to this Authorization, it may be redisclosed by the recipient and the information will no longer be protected by HIPAA. (This would apply only if the party to whom the recipient disclosed personal health information is not subject to HIPAA privacy rules.)
- ◆ The plan may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization.
- ◆ You will be provided with a copy of this Authorization form upon completion and execution.

Signature of Referring Party

Date

Signature of Employee

Date