

To help us to better serve you, please complete the information on this form. NuHealthEAP staff may follow-up with you by phone or questionnaire. You may contact us with any questions that you may have at (887) 273-5886. Thank you!

I hereby authorize NuHealthEAP and its representative(s) and _____ and their representatives (inclusively known hereinafter as the "Parties") to disclose and/or exchange the following information for the following purposes:

Please place your initials in the space next to any items which apply:

_____ **Clinical Information**

The Parties and may disclose and/or exchange information relating to the clinical services I receive(d), to support continuity of care or to inform each other of my status.

_____ **Managed Care**

The Parties may disclose and/or exchange information regarding my treatment for the purpose of precertification, treatment planning and coordination of care.

_____ **Supervisory Referral**

I have been referred to NuHealthEAP by my employer, and in order to comply with the policies of my employer, I authorize NuHealthEAP to release the following non-medical information to my employer:

- (a) whether I have kept initial or subsequent appointments,
- (b) whether a course of treatment was recommended by the EAP,
- (c) whether I am following the recommended course of treatment, and/or
- (d) whether I have completed the recommended course of treatment.

The following named individuals(s) may receive this information:

Name (and position)

Name (and position)

This Authorization shall become effective on _____ and is subject to revocation in writing by me at any time, except to the extent that action has already been taken in reliance on this consent. If not previously revoked, this authorization shall terminate two (2) years from the effective date.

I understand that this information will be used only for the purpose(s) noted above and will not be disclosed to any other person or agency without my written consent. I have read, understand and agree to the terms and conditions set forth in this Consent to Disclose and/or Exchange Information.

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Name of Client (please print) (if a minor child, see below)*

Client signature

Date

I consent for my minor child to be assessed or receive EAP services.*

Name of Client's Parent or Guardian (please print)

Client's Parent or Guardian signature

Date

*If Client is under 18 years of age, the signature of client's parent or guardian is necessary for EAP consultation.