EMPATHIA

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION
EMPLOYEE ASSISTANCE PROGRAM

By completing this form, you are authorizing the disclosure and/or use of individually identifiable health information, as outlined below, consistent with California and Federal law concerning the privacy of such information. All information requested (by "blank" lines) must be provided for this Authorization to be valid.

I, _____ DOB: _____ hereby authorize Empathia Pacific, Inc. and/or its parent company, Empathia, Inc. (in either case, the "EAP") to release any and all information in my EAP case record, including job performance information, diagnosis, treatment plan and services received to _____ (treatment provider). I also authorize _____ (treatment provider) to release any and all information from the evaluation/treatment of me to the EAP. Such disclosure/exchange of information is for the purpose of _____.

This Authorization becomes effective on the date of my signature below and is in effect for one year. A facsimile or photocopy of this Authorization is as valid as the original.

Please note: If you have authorized the disclosure of your mental health information to someone who is not legally required to keep it confidential, it may be re-disclosed and may no longer be protected. California law prohibits recipients of your health information from re-disclosing such information except with your written authorization or as specifically required or permitted by law.

Your rights:

- You may refuse to sign this Authorization.
- You may revoke this Authorization at any time by signing the area below. You may also revoke this Authorization by delivering your revocation in writing to the EAP, Attn: Clinical Director at the following address: 5234 Chesebro Road, Suite 201, Agoura Hills, CA 91301. Your revocation will be effective when received by the EAP. However, this revocation will not extend to information that was already obtained or released (used or disclosed) prior to the revocation.
- You have the right to receive a copy of this Authorization.
- You may inspect or obtain a copy of the mental health information that you are being asked to disclose or allow to be used, within the limits of California and Federal laws.
- Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on your providing or refusing to provide this Authorization.

I hereby relieve and release Empathia Pacific, Inc., Empathia, Inc., and their respective agents and representatives, from any and all damages, claims and causes of action arising out of, or in connection with, any release of this information.

Client Name (Printed) Date Client Signature

To revoke authorization only:

Authorization revoked: _____ (date)

_____

Signature of client