eviCore EAP

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Authorization for Disclosure of Confidential Information

____/___/___ _____ ____/___/___
Date EAP Client Name DOB

I_____(EAP Client), do hereby consent and authorize

_____(Provider) to obtain from and/or release to

_____, the following information pertaining to myself:

☐ Diagnosis/Prognosis/Treatment/Additional treatment recommendations

☐ Other _____

Purpose/need for information (specify the use of the information to be disclosed):

_____

_____

_____

_____

_____

This release cannot be used for the release of HIV – related information, or for the re-disclosure of confidential information provided to you by other individuals or agencies.

I understand that any disclosure is bound by Title 42 of the Code of Federal Regulations (addiction clients), and Mental Hygiene Law Section 33.13 (mental health clients), and that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it. This consent is valid for no more than 6 months after my EAP case is closed. I understand I can contact eviCore EAP at 716.712.2777 if I have questions about anything on this form, or to revoke my consent. You have a right to a copy of this signed authorization and should keep such copy for your records.

_____ ____/___/___ _____ ____/___/_____
Signature of EAP client Date Signature of Witness Date