



**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: \_\_\_\_\_

# 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): \_\_\_\_\_

Referring Manager  
Name (Please print): \_\_\_\_\_

Signature of  
Employee: \_\_\_\_\_

Signature of  
Referring Manager: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Email: \_\_\_\_\_