

Ohio Employee Assistance Program (OEAP)
Authorization for Release of Information

I, _____, of _____
(Name of Employee / Participant) (Employee / Participant's Address)

authorize the **Ohio Employee Assistance Program (OEAP)** to exchange with or obtain from

Treatment Provider: _____
(Name) (Phone Number)

(Address) (City) (State) (Zip Code)

The following information for: **focus of treatment, progress and completion of treatment.**

- This disclosure is made for the following reason: To help coordinate planning and monitoring of compliance or non-compliance with the OEAP Participation Agreement.
- Specific information to be disclosed: Plan of Treatment, employee/participant's compliance with treatment plan, and attendance at scheduled meetings and appointments.
- This consent to disclose may be revoked by me at any time except to the extent that action has been taken in reliance thereon.

This consent (unless expressly revoked earlier) expires on _____ or six months from the date of signature. (Date)

(Employee/Participant) (Date)

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) and section 3701.041 of the Ohio Revised Code and HIPAA standards prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.