Authorization to Use or Disclose Protected Health Information (PHI)
(Employer Referral Case)

1. Member Information

I, _____ (Client Name), _____ (Magellan Case No.), _____ (Date of Birth - MM/DD/YYYY)

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

hereby give permission to Magellan Health, Inc., or any of its subsidiaries or affiliates ("Magellan") and the Magellan staff performing services in connection with my treatment to: either **disclose information to** each of the following and/or **obtain information from** each of the following: (*check one or both boxes*):

☒ _____
and successor or designee of Company Contact

(Name and Job Title of Company Contact) *(Company Name)*

☐ _____

(Name of Provider) *and successor or designee of Provider*

2. Purpose of Use or Disclosure/ Type of Information to be Used/ Disclosed

☒ To verify my EAP participation and compliance with treatment recommendations of the EAP, as required by my employer as a condition of my employment, including the impact of such EAP participation on my attendance at work (estimated time frame for treatment). This may include communication with any third party treatment provider I am referred to outside of the EAP, and communication by Magellan regarding compliance with any treatment plans from the third party treatment providers to my employer. **(Mandatory Referral)**

3. Expiration of Authorization *(check one):*

☐ This date (no more than 1 year from today): _____

☐ This date – 90 days from today [Washington state – all cases]: _____

☒ 6 months after my EAP case is closed.

4. Your Rights

- You can end this authorization at any time by writing to Magellan Health, Inc. Workplace Support, 14100 Magellan Plaza, Maryland Heights, MO 63043. If you make a request to end this authorization, it will not include information that has already been used or disclosed based on your previous permission, including Magellan's ability to confirm information already disclosed in a legal proceeding. For more information about this and other rights, please see your employer's Notice of Privacy Practices.
- Signing this form does not impact your treatment, payment, enrollment, or eligibility with Magellan.
- You do not have to agree to this request to use or disclose your information.
- You have a right to a copy of this signed authorization. Please keep a copy for your records.

5. Re-disclosure By Recipient

Except as described below, information that is disclosed as a result of this Authorization Form may be subject to re-disclosure by the recipient and no longer protected by law. Magellan has to follow laws that protect your health information, but not all persons or organizations have to follow these laws.

If you have questions about anything on this form, call to speak to a Customer Service Representative: 800-450-7281.

6. Signature

_____ (Signature of member) _____ (Date) **OR** _____ (Authorized representative if required) _____ (Date)

If signed by authorized representative, describe authority to act for member: _____

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.