



Valley Baptist

Employee Assistance Program

2121 Pease St., Professional Bldg. B, Ste 3G, Harlingen, TX 78550
 844 Central Boulevard, Professional Tower, Suite 275, Brownsville, TX 78520

RE: AUTHORIZATION TO EXCHANGE AND/OR DISCLOSE INFORMATION WITH VBHS' EAP PROGRAM (RECIPROCALLY)

Name of Employer/Company	Address	Phone
Name of Supervisor		Phone

RE: Provision and exchange of information relevant to job-related supervisory referral.

I, THE CLIENT, DO HEREBY CONSENT TO THE EXCHANGE AND/OR DISCLOSURE OF INFORMATION REGARDING SUPERVISORY REFERRAL. The information will be limited to the work-related information detailed below. No personal information will be released based on this consent:

- Monthly report of dates of attendance at EAP sessions;**
- Degree of compliance with EAP recommendations;**
- Extent of progress toward identified work-related goals;**
- Indication of continued need for services; and**
- Intention for continued participation in EAP services.**

I understand that the information they may share is protected by Federal Regulation 42CFR, Part 2 and cannot be released without my written consent unless otherwise required by law. I understand that I need not consent to the disclosure of information in order to obtain treatment services. I choose to do so willingly and voluntarily for the purpose specified above. The duration of this authorization is no longer than one year unless I specify a date, event or condition upon which it will expire sooner. I understand that I may revoke this consent at any time by notifying my therapist, in writing, except to the extent that action has been taken in good faith on my consent.

SIGNATURE OF CLIENT

DATE

Print Patient Name

DOB

SS # or EMPLOYER I.D.#

Supervisor: Have client fill out and take to EAP.