EMPLOYEE ASSISTANCE PROGRAM MANAGEMENT REFERRAL FORM

Please complete and fax to 1-888-892-8832 or call 1-800-243-5240 to make a referral, then mail this form to:

Horizon Health EAP Services
Management Resource Center
410 17th Street, Suite 300
Denver, CO 80202

MRC: Nancy Charles M.A., LPC
1-800-327-2287 #3 x488

Company Name: ______________________ Location: ______________________

Department: ______________________ Phone: ( ) ______________________

Referring Party: ______________________ Title: ______________________

Client Referred: ______________________ DOB: / /

Client's Phone: Work: ( ) ______________________ Home: ( ) ______________________

Client's Insurance: ______________________ SSN: ______________________

Reason for Referral (complete or attach documentation describing reason/job performance issues):

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Last Chance Agreement: (attach if written) Yes ☐ No ☐ Deadline Employee Must Call for Appt: / /

To the Employee: By signing this form, you are allowing Horizon Health EAP Services to release the following information:

Scope of Release: ☐ Alcohol/Drug Evaluation/Treatment ☐ Attendance ☐ Recommendations/Follow Through ☐ Compliance

To the following person(s):

Name	Title	Phone
		( )
		( )

Relation of above person(s) to client: ______________________

Purpose of releasing information: ☐ To track compliance with treatment recommendations

☐ Other (please specify) ______________________

This release expires on the following date: / /

AUTHORIZATION

This authorization for use or disclosure of medical information is being authorized by me giving Horizon Health EAP permission to disclose medical/psychiatric records and information obtained in the course of diagnosis and/or treatment. I understand that the medical records and information to be released may contain information pertaining to psychiatric, drug and/or alcohol related evaluation and/or treatment compliance.

Your rights:

- You may revoke this Authorization at any time by submitting a written revocation to Horizon Health EAP at the address at the top of this page.
- A revocation will not apply to information that has already been used or disclosed in reliance on this Authorization.
- Once information is disclosed pursuant to this Authorization, it may be redisclosed by the recipient and the information will no longer be protected by HIPAA. (This would apply only if the party to whom the recipient disclosed personal health information is not subject to HIPAA privacy rules.)
- The plan may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization.
- You will be provided with a copy of this Authorization form upon completion and execution.

Signature of Referring Party	Date	Signature of Employee	Date