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Informed Consent

I hereby authorize WellSpan EAP to disclose information to: _____
(Primary Contact Name/Phone Number)

(Secondary Contact Name/Phone Number)

from the records of: _____
(Employee's Name) (Social Security Number)

(Home Address) (Home Telephone Number) (Date of Birth)

Information to be released: By my signature below, I recognize that the information to be released may include my attendance at EAP sessions used in addressing the reason for this referral, and recommendations that may be provided to me or my employer regarding this referral. Attendance at EAP sessions may include scheduled appointment dates and attendance at those sessions, missed appointments, etc. Recommendations may include, but is not limited to, suggestions made by my treatment provider regarding referral for treatment beyond EAP sessions, recommendations for follow-up drug/alcohol testing (if referral was made for substance use/abuse), and suggestions for my employer in assisting me with resolving the issue being addressed by this referral.

This information is being disclosed to the above person(s), organization or agency from records whose confidentiality may be protected by the Drug and Alcohol Abuse Control Act (Pennsylvania Law, Act 63) and/or the Mental Health Procedures Act (Pennsylvania P.L. 817) and/or Confidentiality of Alcohol and Drug Abuse Patient Record Regulations (Federal Public Law 93-282) or, in accordance with the state where you receive services. My signature below authorizes release of all such information by routine/express mail service or facsimile transaction.

I understand that I have no obligation whatsoever to disclose information from my record and understand that I may revoke this authorization at any time in writing, except to the extent that action based on this consent has been taken. I fully understand the contents of this authorization and voluntarily consent to the release of the information as stated.

This authorization shall expire 1 year from the date executed unless otherwise specified by the client (employee).

(Print Employee's full name)

(Witness Signature) (Date)

(Signature of Employee/Responsible party) (Date)

Note: This authorization will not be accepted unless it is completed in its entirety. A copy of the form will be accepted in Lieu of an original.