



TREATMENT / REHABILITATION AUTHORIZATION RELEASE OF INFORMATION FORM



The purpose of this form is to authorize the release of information in order to verify an employee's treatment/rehabilitation status by the Department of Administration's EAP Administrator and the Employee's Department Employee Assistance Program Counselor. **TREATMENT / REHABILITATION VERIFICATION MUST BE RETURNED TO DOA**

PART A: DEPARTMENT/AGENCY (To be completed by Department/Agency's EAP Representative)

Employee's Name: _____ Social Security Number: XXX-XX
 Position Title: _____ Employee ID: _____
 Department: _____ Section: _____
 Mailing Address: _____ EAP Referral Date: _____

PART B: EMPLOYEE AUTHORIZATION (To be completed by Employee)

I _____, hereby authorize the Guam Behavioral Health and Wellness Center (GBHWC) or any treatment facility approved by GBHWC to release and disclose information to Department of Administration's Employee Assistance Program Administrator and my Department's Employee Assistance Program Counselor regarding the rehabilitation and treatment program for the following:

- 1) Attendance or Non-Attendance at EAP related sessions. **Information will not include diagnostic or clinical disclosure.**
- 2) Suggestions, if any, resulting from the EAP assessment regarding workplace/supervisory strategy that may support improved work performance. **Information will not include diagnostic or clinical disclosure.**
- 3) Recommendation(s), if any, resulting from the EAP assessment. Information shall be limited to identifying the **level of care:** (outpatient, partial hospitalization, inpatient or residential), **type of referral resource(s)** : (self-help, support groups, medical evaluation, etc.), the **name of treating provider and/or facility if requested for purposes of ongoing follow-up, whether follow-up drug testing is required while in the program, and how long up to one year should follow-up drug testing occur after completion of program.** **Information will not include diagnostic or clinical disclosure.**
- 4) The estimated time frame necessary to complete the recommendation(s). **Information will not include diagnostic or clinical disclosure.**
- 5) The employee's demonstrated compliance or non-compliance with initial follow-through of the recommendation(s). **Information will not include diagnostic or clinical disclosure.**

I understand that my department/agency is referring me to the Employee Assistance Program. My signature verifies that I have reviewed this referral and authorize the release of the above-mentioned as indicated on this form.

Employee Signature

XXX-XX-
Last 4 digits of SSN#

Date

PART C: DEPARTMENT OF ADMINISTRATION (To be completed by the DOA EAP Administrator)

Copy to Dept's EAP Counselor? Yes ___ No ___

EAP STAMP RECEIVED:

DOA EAP Administrator Signature