TREATMENT / REHABILITATION AUTHORIZATION

The purpose of this form is to inform the Department of Mental Health and Substance Abuse (MHSA) or any treatment and rehabilitation facility approved by the MHSA to provide information to the Department of Administration's Employee Assistance Program Administrator / Drug-Free Workplace Coordinator and/or official representatives.

TREATMENT / REHABILITATION VERIFICATION MUST BE RETURNED TO DOA

PART A: EMPLOYEE INFORMATION (*To be completed by Department/Agency's EAP Representative)*

Employee's Name: _____ **Social Security Number**: XXX-XX-_____

Position Title: _____ **Date of Birth**: _____

Department: _____ **Section:** _____

Mailing Address: _____ _____

EAP Referral Date: _____

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

I_____, hereby authorize the Department of Mental Health and Substance Abuse (MHSA) or any treatment facility approved by MSHA to release and disclose information to Department of Administration's Employee Assistance Program Administrator / Drug-Free Workplace Coordinator and my Department's Employee Assistance Program Representative regarding the educational and treatment program for the following:

1) Attendance or Non-Attendance at EAP session(s). ***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.** ***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. I also understand that my signature below does not reflect my agreement or disagreement with any of the issues raised. My signature verifies that I have seen this referral and all documentation contained therein.

_____ XXX-XX-_____

Employee Signature Last 4 digits of SSN#

_____

Date

PART C: (*To be completed by the Department of Administration – Drug-Free Workplace Coordinator / EAP Administrator)*

_____ Signature of DOA DFWP Coordinator / EAP Administrator	DFWP – EAP STAMP RECEIVED:

********** NOTHING AS FOLLOWS **********