

**MANAGEMENT REQUESTED REFERRAL  
AUTHORIZATION FOR DISCLOSURE OR EXCHANGE OF INFORMATION**

I, \_\_\_\_\_, with a social security number of \_\_\_\_\_, do hereby acknowledge that I have been referred by my supervisor for an assessment and/or treatment through the Employee Assistance Program (EAP).

I further acknowledge that this request for EAP services is in part do to concerns about my job performance. Consequently, I understand that it will be necessary for my employer to provide information about my job performance to P.A.C.T. (the EAP provider) and P.A.C.T. to provide feedback to my employer. Information provided by my employer may include but is not limited to performance reviews, attendance, behaviors/attitudes, workplace interactions, etc. Information exchanged by P.A.C.T. is specified below. I understand that this exchange of information is done for the purpose of facilitating my employer's and/or EAP clinician's understanding of factors that may contribute to my performance and health in the workplace.

I acknowledge that information to be used or disclosed as a result of this Authorization may include records that are protected by federal and/or state laws applicable to substance abuse. The recipient of drug and/or alcohol abuse information disclosed as a result of this Authorization will need my further written authorization to re-disclose this information.

I understand that I have the legal right to grant this authorization for release of information. Further, I have the right to receive a copy of this Authorization. This Authorization expires upon completion of all follow-up associated with such referral or one year from the date granted whichever is later.

I may take back ("revoke") this Authorization at any time. I must do this in writing, signed by me or on my behalf, and delivered to P.A.C.T., 903 Forest St., Georgetown, TX 78626.

My revocation will be effective upon receipt, but will not affect actions already taken on the basis of this Authorization.

Therefore, I do hereby consent to the disclosure and/or exchange of information, as specified below, between P.A.C.T. and \_\_\_\_\_, Representative of my employer

Purpose of requested disclosure or exchange:

- Compliance and/or non-compliance with formal or mandatory referral by employer;
- Evaluation of Fitness for Duty;
- Notification to the employer of compliance with EAP recommendations
- \_\_\_\_\_

This Authorization applies to only the following records or types of health information

- Contact(s) with the EAP;
- Participation or non-participation in recommended plan of action;
- Continuation or discontinuation in recommended plan of action; and/or
- Status of Fitness for Duty
- \_\_\_\_\_

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date