HORIZON HEALTH EMPLOYEE ASSISTANCE PROGRAM
MANAGEMENT REFERRAL FORM

To initiate a Management Referral, please call 1-800-243-5240. Immediately after the call, fax completed form to 1-888-892-8832

Management Resource Center

MRC: ____________________________

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: / /

<u>To the Employee</u>*:* 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: / / **1 Year or less per HIPAA**

AUTHORIZATION

This authorization for use or disclosure of information is being authorized by me giving Horizon Health EAP permission to disclose information (checked off above) obtained in the course of assessment. I understand that the information to be released may contain information pertaining to mental health, 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.
- 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