EMPLOYEE ASSISTANCE PROGRAM

PERMISSION FOR COUNSELING and NOTICE OF PRIVACY PRACTICES

Permission for Counseling I hereby grant permission to the EAP designated counselor to provide such care as may be necessary for me and/or the client named below. I have been given an opportunity to discuss my or the client's conditions with the appropriate personnel.

I understand that my legal right to confidentiality will be maintained except at times when the EAP designated counselor is required ***by law*** to make disclosures in cases of: 1) child/elder abuse or neglect, 2) homicide or intent to harm someone, 3) or suicidal intent. In those cases, I understand that the counselor will have to notify the appropriate agency personnel and legal authorities in accordance with applicable local, state and federal laws. I also understand that, if I have been referred for EAP services by my employer, the EAP designated counselor may be required to disclose certain limited information, such as my attendance at appointments, to my employer in accordance with my employer's requirements. I understand that this information will ***not*** be provided to my employer unless I have signed an Authorization for Release of Information form.

Notice of Privacy Practices I acknowledge that I have received a copy of the Community Health Network and The Indiana Heart Hospital Notice of Privacy Practices Notice of Privacy Practices that describes how medical information about me may be used and disclosed and how I can get access to this information.

Permission to Transmit Records I give permission to have my clinical records transmitted by fax to the Hillsdale Office where EAP's central records are kept.

_____

Signature
(Client/Other Legally Responsible Person)

_____

Printed Name

_____

Date

_____

Witness

Please send completed to EAP with assessment form at 1st appointment