



**AUTHORIZATION FOR LIMITED RELEASE/EXCHANGE OF CONFIDENTIAL INFORMATION**

On this \_\_\_\_\_ day of \_\_\_\_\_, I \_\_\_\_\_  
(Day) (Month) (Printed Name)

\_\_\_\_\_  
(Address)

authorize: CLINICAL REPRESENTATIVE OF PENN Behavioral Health through the EAP

(\_\_\_\_\_)  
(Name)

\_\_\_\_\_  
(Address)

to release limited confidential information to: MY ORGANIZATIONAL OFFICIAL  
(Human Resources or Equivalent Organizational Representative)

(\_\_\_\_\_)  
(Name)

\_\_\_\_\_  
(Company Site Address)

The specific information to be released is limited to the following:

- A. DID EMPLOYEE ATTEND PENN BEHAVIORAL HEALTH COUNSELING SESSION(S)?
- B. WERE FURTHER RECOMMENDATIONS MADE?
- C. DID EMPLOYEE MAKE CONTACT WITH FURTHER RECOMMENDATIONS?

and pertains to services received during: MONTH(S) (\_\_\_\_\_)  
(Date)

This information is needed for the following purposes: COMPLIANCE WITH FORMAL REFERRAL

\_\_\_\_\_  
**Signature of Clinical Representative**

\_\_\_\_\_  
**Signature of Client**

\_\_\_\_\_  
**Witness (if applicable)**

\_\_\_\_\_  
**Client's Printed Name**                      **Date**

- + The confidentiality of any information received or disclosed by the use of this authorization is protected by Federal Law 93-282. Federal Regulation (42 CFR Part 2, Section 2.32) prohibits any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.
- + This authorization is void after 90 days from the date of client/responsible agent's signature.