Department of Human Resources
**Division of Employee Benefits**
1180 S. Main Street, Suite 378
Akron, Ohio 44301

Authorization for

# 2082 Release of Confidential Information

| **Employee name** *(Last)* | *(First)* | *(MI)* | **Date of birth** |
|---|---|---|---|
| | | | |

I consent to The Centers for Families and Children, doing business as **EASE@WORK** (herein after "**EASE@WORK**"), obtaining the quantitative results of any and all alcohol and drug testing that occurred through my employer, the County of Summit, on ______________________.

| Organization<br>**FROM: Summa Health Corporate Health** | | Organization<br>**TO: EASE@WORK (EAP)** | |
|---|---|---|---|
| Attn:<br>**Gaye Williams** | | Attn:<br>**Intake Department** | |
| Full address<br>**1860 State Road, Suite C, Cuyahoga Falls, OH 44221** | | Full address<br>**4500 Euclid Avenue, Cleveland, OH 44103** | |
| Telephone number<br>**330.940.5738** | Fax number<br>**330.940.5769** | Telephone number<br>**800.521.3273** | Fax number<br>**216.432.7255** |
| E-mail<br>**williamsgl@summahealth.org** | | E-mail<br>**intake@easeatwork.com** | |

## THE PURPOSE OF THIS DISCLOSURE

☒ Coordination of care

**I understand that information disclosed is protected by law** and may not be re-disclosed, except between or among the parties named above, without my written authorization or as otherwise authorized by law. I also understand that **EASE@WORK** cannot control the recipient's use of the information.

**I understand that my records are protected under federal law** governing confidentiality of drug and alcohol records, including Title 42 CPR, parts 2, 160, and 164, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I also understand that my enrollment or eligibility for benefits cannot be conditioned upon my giving authorization for disclosure of information, except as otherwise provided by law and except that **EASE@WORK** may condition treatment on my giving authorization for disclosure of information if the sole purpose for the treatment is to provide information to a third party (such as my employer under a management referral or fitness-for-duty evaluation).

**I understand that this authorization is voluntary.** I may revoke this authorization at any time by signing the revocation that is part of the authorization and mailing it, postage prepaid, to **EASE@WORK**, Attn: Manager of Clinical Services, except as otherwise provided by law and except in cases where **EASE@WORK** has already taken action based on this authorization. I understand that any information released prior to revocation cannot be retrieved and **EASE@WORK** will not be held responsible for such. I hereby release **EASE@WORK** from all legal responsibilities or liability that may arise from any use or disclosure of information that occurred prior to revocation.

**This authorization automatically becomes invalid** six (6) months from the date signed. I have read and understand this authorization. If I have questions about it, I may contact the manager of clinical services at **EASE@WORK**.

### Employee

▶ ______________________________ ▶ ____________

**Signature of employee** **Date**

▶ ______________________________ ▶ ____________

**If appropriate, signature of parent/guardian/personal representative with description of relationship and authority to act on client's behalf** **Date**

### Representative

▶ ______________________________ ▶ ____________

**Signature of County of Summit HRD representative or manager facilitating request for disclosure of information** **Date**

______________________________

**Printed name and title**

### I REVOKE THIS AUTHORIZATION:

▶ ______________________________ ▶ ____________

**Employee signature** **Date**