Nadeen Medvin, Ph.D., DABPS, DABDA
Licensed Clinical and Industrial/Organizational Psychologist

Authorization for Use and Disclosure of Private and Confidential Health Information

THIS FORM WILL ALLOW YOUR HEALTHCARE PROVIDER/S TO RELEASE THE
PRIVATE HEALTH INFORMATION SPECIFIED BELOW TO THE PERSONS OR ENTITIES SPECIFIED ON THIS FORM

Description of Private Health Information to be Released:

- ☐ 1) Attendance or Non-Attendance at EAP &/or medical appointments.
- ☐ 2) Suggestions, if any, resulting from the EAP / medical assessment regarding workplace/supervisory strategies which may support improved work performance. (Suggestions do not include diagnostic or clinical disclosure)
- ☐ 3) Recommendation/s, if any, resulting from the EAP / medical assessment; information shall be limited to identifying the level of care: (outpatient, partial hospitalization, inpatient or residential), type of referral resource/s: (self-help, support groups, medical evaluation, etc.), the name of the treating provider and/or facility if requested for purposes of ongoing follow-up care.
- ☐ 4) The estimated time-frame necessary to complete the recommendation/s.
- ☐ 5) The employee's demonstrated compliance or non-compliance with initial follow-through of the recommendation/s.
- ☐ 6) Other: _____

Note: No Additional Clinical Information Will Be Disclosed.

Verification:

Identification of person authorizing release: (The following information is needed for verification. Please complete all applicable items.)

Name of Participant: _____

Date of Birth: _____ Phone #: _____

Address: _____

Participant's Employer Name: _____ Participant's Social Security Number: _____

I authorize the persons or entities below to receive the information:

(Name of person or entity and entity's contact person, address and phone number must be provided)

Dr. Nadeen Medvin, 444 SW 2nd Ave – 7th Floor, Miami, FL 33130. *Phone:* (305) 815-1129
E-Mail: DrNadeenMedvin@aol.com

Other:

_____
_____
_____
_____
_____
_____
_____

Purpose of this release of information:

- ☐ To confirm the employee's medical treatment and continuity of care needs are being met and to assist in restoring and maintaining optimal attendance, job performance and/or reassignment.

Other: _____

This authorization expires: 60 days following discharge from and/or completion of treatment or education as recommended by the EAP / medical provider _____ (to be completed by Participant)
(date or event)

I understand that information used or disclosed based on this authorization is permitted to be disclosed if the City in good faith believes said information is necessary to prevent or lessen a serious and imminent threat to my health or safety or in cases where required by law and consistent with applicable standards of ethical conduct.

I understand that if information on this form is not complete, the form will be returned to me, and this request will not be considered until all information has been received.

I understand that I may revoke this authorization by sending a written request to my healthcare provider/s and those individuals listed above. Any revocation will not be effective for any actions that may already have been taken.

Signature:

I have read and understand the above information: Date: _____

Signature of Participant, Parent/Guardian, or Personal Representative **X**_____

Relationship if person signing is other than Participant: _____

Note that, if not already provided, we will require verification of the authority of a Personal Representative before this request will be considered complete.

If request is made by a Parent/Guardian, complete the following: Participant is a minor _____ years of age. If you are making this request on behalf of a minor child, we may require additional information before this request is considered complete.

TO THE RECIPIENT OF PRIVATE AND CONFIDENTIAL INFORMATION

If the information disclosed to you relates to substance abuse treatment, in addition to HIPAA Privacy regulations, these records' confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of the information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient to release substance abuse records. The Federal Rules restrict any use of the information to criminally investigate or prosecute any substance abuse patient. State laws may also protect the privacy of patients' records, and may be more restrictive than applicable federal regulations.