TEAM
Wellness at Work

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

1. Member Information

Member's Name: _____ Birthdate: _____
Street Address: _____ SSN#: _____
City, State, Zip: _____
Maiden/Other Names: _____ Phone #: (home) _____ (work) _____

I, _____, voluntarily authorize TEAM Corporation, 1970 Oakcrest Ave., #200, Roseville, MN 55113
(Name of Member)

☐ TO DISCLOSE TO: ☐ TO RECEIVE FROM: ☐ TO EXCHANGE WITH:

2. The following person/organization:

NAME: _____
ORGANIZATION (if applicable): _____
PHONE: _____
FAX: _____
ADDRESS/E-MAIL: _____

3. Specific description of the information to be disclosed. Check and initial the following:

☐ ___ Appointment Verification ☐ ___ Compliance Status ☐ ___ Return to Work Notice
☐ ___ Client Demographics ☐ ___ Clinical Information ☐ ___ Other: _____

The following information requires special consent by law. Even if you indicate all health information, you must specifically request the following information in order for it to be released:

☐ ___ Alcohol/Drug Abuse Treatment Records ☐ ___ Counseling Records

4. The purpose of this request is:

☐ Fitness for Duty (FFD) Referral ☐ Coordination of Care/Treatment ☐ Other: _____
☐ Referral for Treatment ☐ Supervisory Referral ☐ Other: _____

5. Acknowledgement

- I understand that information to be released or disclosed under this Authorization may be confidential in nature, and may include clinical impressions and clinical conclusions of providers.
- I understand the following consequences may occur by refusing to sign this release: 1) If Authorization is to demonstrate to a health plan that a service should be paid for, the health plan may refuse to pay for it; and 2) If the Authorization is sought by an insurer because I am seeking enrollment or eligibility, the insurer may deny me coverage.

[Please turn to the back of this page]

- This Authorization becomes effective on the date I sign it, and will continue in effect for twelve (12) months from that date unless I revoke it in writing before that time. I understand I can revoke this Authorization at any time, but information released before revocation cannot be retrieved. I may revoke this Authorization by sending a written revocation to: Privacy Officer, TEAM Corporation, 1970 Oakcrest Avenue, Suite 200, Roseville, MN 55113
- I acknowledge the potential that the information disclosed pursuant to this Authorization may be subject to redisclosure by the recipient, and thus no longer protected by federal health information privacy laws.
- I understand that TEAM will not limit treatment under, payment for, enrollment in and eligibility for EAP benefits based on my agreement or refusal to sign this Authorization
- I agree that a photocopy or facsimile copy of this Authorization is as valid as the original.
- I understand TEAM Corporation will give me a copy of this Authorization.

6. Signature(s)

Signed: _____ Date: _____

If the client is a minor, I authorize the release of the above information.

Signed: _____ Date: _____