



AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ {Employee Name}, authorize **TMHC Services Inc.**, and/or its agents/service providers, to release the following individually identifiable health information to the **Designated Employer Representative (DER)** of _____ (**Your Company Name**). The purpose of this disclosure is to inform the **DER** of my compliance with this mandatory referral.

1. My initial contact with the Employee Assistance Program (EAP) counselor, Qualified Mental Health Professional (QMHP) or Substance Abuse Professional (SAP).
2. Confirmation of a face-to-face assessment/evaluation (for Mental Health or Substance Abuse), including the results of the assessment/evaluation (for Mental Health or Substance Abuse) of me by the QMHP or SAP and any recommendations the QMHP or SAP has made for treatment as outlined in the Mandatory Referral Checklist.
3. Confirmation of my admittance, including the date and estimated length of stay, to an appropriate treatment program (for Mental Health or Substance Abuse).
4. Confirmation of my attendance at all scheduled treatment appointments (for Mental Health or Substance Abuse).
5. My completion of the treatment program (for Mental Health or Substance Abuse).
6. My positive drug and/or alcohol test results.

I understand that this authorization will be valid for 90 days after my completion of the treatment program. Employee's initials _____.

I also understand I may revoke this authorization at any time, except to the extent that the authorization has already been relied upon, by submitting such revocation in writing to the **Designated Employer Representative** of _____ (**Your Company Name**) and **TMHC Services Inc.** Employee's initials _____.

Employee Name (Printed): _____
(Or Employee's Representative)

Relationship of Employee's Representative to Employee: _____

Employee Social Security Number: _____

Signature of Employee or Employee's Representative: _____ Date: _____

Witness: _____ Date: _____

TMHC Services, Inc.
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