Authorization to Obtain/Exchange Attendance Information

Patient Name	Date of Birth *(mm/dd/yyyy)*

Street Address	City	State	Zip Code

I hereby authorize...

AllOne Health Provider

to exchange and/or disclose information regarding the attendance of the above-named person to

Name of Supervisor

I specifically request that only information on my attendance be released/exchanged. I understand this information will be used to notify the above person as to whether or not I am following through on attendance of EAP services and will not be used to disclose personal information such as the problem(s) I am facing or to identify the resource(s) I have agreed to utilize.

The doctrine of the informed consent has been explained to me, and I understand the contents to be released, the need for information, and that there are statutes and regulations protecting the confidentiality of authorized information. I hereby acknowledge that this consent is voluntary and is valid for a period not to exceed one (1) year. I further acknowledge that I may revoke this consent at any time except where actions based on this consent have already been taken.

I agree that a photocopy/fax of this authorization is to be considered as effective as the original.

Signature of Employee	Date *(mm/dd/yyyy)*

Signature of AllOne Health Clinician/Provider	Date *(mm/dd/yyyy)*