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MCLEOD REGIONAL MEDICAL CENTER

The Choice for Medical Excellence

AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Created 2015 Reviewed 12-4-2018; 3-23-21 Revised 12-4-18; 2-19-2020; 3-23-21; 5-26-22, 7-27-23

Patient Name: _____ Date of Birth: _____

Address: _____ Employee ID #_____

_____ Patient# or MR#: n/a

I authorize Advanced Practice Mental Health & Wellness of SC _____ to use or disclose my "protected health information" (PHI)

to: McLeod Employee Assistance Program, 800 East Cheves Street, Suite #320, Florence, SC 29505

Recipient Name **Address** **City** **State** **Zip**

Information for treatment period: **From (date)**_____ **To (date)** 30 days after closing of acct. _____

- ☐ Discharge Summary
- ☐ History and Physical Examination
- ☐ Consultation
- ☐ Pathology Reports
- ☐ Laboratory Tests
- ☐ Radiology Reports
- ☐ Operative Notes
- ☐ Emergency Department Reports
- ☑ Other (please specify: Case consultation and coordination of care
- ☐ 42CFR (Substance Abuse)

Purpose(s): ☐ Legal Investigation ☐ Insurance ☐ Disability Determination ☑ Other

OR: ☐ I request my information be released to me to exercise my right to access and obtain a copy of my PHI.

A.) I understand that PHI may include records disclosed by health care providers and facilities that previously provided treatment to me.

B.) I understand that PHI may include information and records protected under Federal Law (such as alcohol and drug abuse treatment) and/or State Law (such as mental health, AIDS or HIV).

C.) I understand I may revoke this Authorization at any time however the revocation will not apply to PHI that has already been used or disclosed pursuant to this authorization. Contact the Privacy Official to initiate the revocation process.

D.) I understand that McLeod Health will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

E.) I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal privacy standards.

F.) I understand that this Authorization will expire in 90 days after it is signed unless another date is specified here _____.

I have read and understand this Authorization. I certify that I am the Patient listed above or a person authorized to permit release of records on the Patient's behalf. I hereby release the Provider (as named above) from any liability or damages arising in connection or related to with the use and/or disclosure of my protected health information pursuant to this Authorization.

Print Patient Name	Patient Signature	Date
Authorized Representative	Relationship to Patient	Telephone Number

PROVIDER USE ONLY: Received on _____ Disclosure on_____ Copy to Patient on _____

Disclosure by: _____ Authority: _____

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Employee Assistance Program Intake Form

Date_____

Client Full Name:_____
(First Name - MI - Last Name)

Home Address:_____City/State/Zip:_____

Birthdate: _____ Age:_____ Sex: _____ SS# _____

Home #: _____ Work #: _____Cell #: _____

Education: _____ Ethnic background: _____ Marital Status: Married/Divorced/Sep/Single/Widow

Client is: ☐ Employee ☐ Spouse ☐ Dependent

Employee's status: ☐ Full-Time ☐ Part-Time ☐ PRN

How did you learn about the EAP? _____ Referred by: _____

Emergency Contact: _____
(Name) (Relationship) (Phone Number)

Insurance Company: _____ Insured's SS#_____

Policy/Member #: _____

EMPLOYEE INFORMATION

Employee name (if different from above) _____ **DOB**: _____

Which company do you work for? (Check one below)

McLeod _____/McLeod Campus: _____/ McLeod Employee ID# _____

Charles Ingram Lumber _____	City of Florence ____	CareSouth _____	Chester/Marlboro _____
Florence Reg Airport ____	Housing Author ____	MPD _____	McCall Farms _____
Nucor ___	Nucor Cold Finish _____	Vulcraft _____	Ruiz Foods _____
SteelFab _____	Trinity BH _____		

Department/Job Title: _____**Work Phone:** _____ **Hire date:** _____

Created: 8/23/22
Revised: 6-12-23; 3-28-24; 6/26/24

McLeod Health Employee Assistance Program
Statement of Understanding

Your Employee Assistance Program (EAP) is offered to you and your family members to assist in the resolution of personal problems. When left unattended, personal problems can negatively affect many areas of your life including your family and job. Your employer is invested in having a healthy and productive work force.

In general, the choice to use EAP is voluntary. Using or not using EAP services, within itself, neither saves nor jeopardizes your job. If there is a job performance problem, it is your responsibility to take appropriate action to resolve this problem with your supervisor. The EAP is simply a resource made available to you to assist you in problem resolution. On rare occasions, when an employee's ability to work safely is questioned, that employee may be required to attend EAP to determine whether he/she is safe to work.

The services you receive through the McLeod EAP are confidential as required by legal and ethical standards. Records of services are maintained separately and are not shared with your employer. Information will not be released unless:

1. an authorization form has been signed authorizing disclosure.
2. there is a threat of harm to self or others, thereby establishing a "duty to protect."
3. abuse of a vulnerable person (for example, a child her elderly person) is indicated, thereby requiring a report to the appropriate authorities.
4. an employee is determined to be unfit for duty, as defined by being unable to safely perform their job.
5. required by law, such as a court order.

When a formal supervisory referral is made, the supervisor will be informed of the employee's participation. Further information will not be disclosed without a "release of information" authorization form being signed.

You have the right as an EAP client to be treated with dignity and respect. You have the right to be informed of the EAP staff's assessment and recommendations for treatment.

I have read this Statement of Understanding and understand its contents.

_____ _____
Client's Signature (Parent or Guardian, if client is a minor) Date

_____ _____
Employee Assistance Staff Member Date

EAP Appointment Reminders

(CHECK ONE) The Employee Assistance Program ☐ **may** / ☐ **may not** send me appointment reminders by text message. If I agree to text reminders, I understand that standard data fees and text messaging rates may apply based on my mobile phone plan. I may opt out of text delivery at any time by replying STOP to a reminder text.

_____ _____
Initials Date

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that on _____ I received a paper copy of the McLeod Health Notice of Privacy Practices which sets forth the way in which my protected health information may be used or disclosed by McLeod Health and outlines my rights with respect to such information. I also acknowledge that I have been allowed to ask questions. If I am not the patient, I represent that I am authorized by law to act for and on the patient's behalf.

_____ _____
Signature of Patient or Authorized Agent Date

Are you willing to participate in a client satisfaction survey to assist the EAP and quality improvements? ☐ Yes ☐ No

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Special Situations

Health Oversight Activities – We may make known your medical information to a government agency, such as DHEC, for health oversight activities such as inspections or to give a license to the people who treat you at McLeod. These activities are necessary for the government to monitor the health care system, programs, and to obey with laws.

Lawsuits and Law Enforcement – We may make known your medical information to answer a court order or search warrant. We also may make known your medical information to answer a subpoena but only if efforts have been made to provide you the option to object or to obtain a court order to protect the information. Subject to certain conditions, we may make known your medical information for a lawful purpose if asked by a law official such as locating a suspect.

Coroners, Medical Examiners and Funeral Directors – We may make known your medical information so they may carry out their duties.

Minors – McLeod will obey the South Carolina law about minors. We may give out certain types of your medical information to your parent or guardian if it is required or permitted by law.

Specialized Government Functions – We may give out your medical information to obey military and veteran rules. We may make known your medical information to approved federal officials for lawful security activities or to provide protection to the President. We may disclose the medical information of an inmate or person in custody to a correctional institute or law official to provide them health care or to protect their health and safety or the health and safety of others.

Organ and Tissue Donation – If you are an organ donor, we may make known your medical information to organizations that handle the donation process.

Public Health – We may make known your medical information for public health purposes. Examples include: to prevent or control disease, injury or disability; to report births; or to report drug reactions.

Workers' Compensation – We may make known medical information about you for workers' compensation or similar programs.

Food and Drug Administration (FDA) – We may make known your health information to help fix food, drug, supplements and medical equipment problems.

Other Uses & Disclosures

Business Associates – We may disclose health information to our business associates that perform functions on our behalf and provide us with services. All of our business associates are obligated to protect the privacy and security of your information and are not allowed to use or disclose any information other than as specified in our contract.

Those who help take care of you – We may use your health information to tell a family member or other person involved in your care about your care, location, and general condition. This will be done by the best judgment of the people who gave you care at McLeod Health, unless you object.

Right to Change Practices

We have the right to change these practices about protected health information that we create and/or maintain. The most current practices will be posted on the McLeod website and in our buildings near the registration desk.

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Employee Assistance Program

PARENTAL CONSENT

As parent or legal guardian of _____, I hereby grant
(name of child/adolescent)
permission to the McLeod Employee Assistance Program to provide assessment and/or treatment services to this minor child/adolescent. This consent for treatment will expire thirty (30) days after case closing unless specifically revoked prior to that date.

Signed: _____

Date: _____

Witness: _____