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# FORMAL SUPERVISORY REFERRAL

*Authorization to Release Confidential Information*

I, _____
*(EAP Participant)*

Authorize _____
*(Treating Clinician)*

To disclose the following information to my immediate DEA Supervisor _____

_____ regarding my participation with this referral:
*(DEA Supervisor)*

- Date of my initial contact with the Clinician.
- Date(s) of each session with the Clinician.
- Date of my termination of sessions with the Clinician.
- Total number of sessions with the Clinician.
- A general assessment of my level of cooperativeness/participation with the clinical process and success in addressing the reasons for the referral (as stated in the Referral Memo).
- Any information or issues in which the Clinician and I mutually agree are essential in order for my Supervisor to participate in the resolution of the referral problems(s), or to initiate a problem-solving dialog with the Clinician and/or me.

I understand that my records are protected under the Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that, in any event, this consent expires automatically. (Specify date, event, or condition upon which this consent expires)

_____

_____

*(NOTE: Refusal to sign the consent for a Formal Supervisory Referral will immediately terminate the clinical process and the clinician will inform the Administrative Clinician and EAP Program Office of the refusal in writing. The EAP Administrator will refer case back to the manager for administrative handling and resolution.)*

_____ _____
(Signature of Participant) (Date)