beacon
health options

AUTHORIZATION TO DISCLOSE INFORMATION FOR FORMAL OR MANDATORY REFERRALS TO THE EAP

By completing this form you allow Beacon Health Options, Inc. to disclose information to the individuals you identify in order to report your compliance and/or noncompliance with a formal or mandatory referral to the EAP from your employer.

SECTION 1: Identify the person whose information is to be released:

Name: Sakinder Ali
Member ID# M41404
Phone Number: 240-751-5984

Employed by: Northrop Grumman
DOB: 6/1/1982
Email: sakinder@live.com;sakinder.ali@ngc.com

SECTION 2: Identify the person(s) or entity who is to receive the information:

Print the Name(s) of person receiving records:

Name: Katyna Christian, LPC-S, CEAP
Title/ Company: Global Manager, EAP and Work/Life Solutions
Phone: 214-524-0328 Email: katyna.christian@ngc.com

Name: Lea Metellus
Title/ Company: Human Resources Business Partner
Phone: 410-993-7777 Email: Lea.Metellus@ngc.com

Print the Name of person(s) receiving records:

Name: Sue Brunson,BSN, RN,PMP
Title/ Company: Director, Wellness Services
Phone: 410-765-4286 Email susan.brunson@ngc.com

SECTION 3: Identify what information may be released:

☒ Whether or not the employee contacted EAP, including dates of contact;

☒ Participation or non-participation in the EAP-recommended plan of action

If no additional information is required by the person(s) in section 2, proceed to Section 4

SECTION 3A:

By initialing and checking any items in Section 3A, you are further authorizing Beacon Health Options, Inc. to release specific types of additional information which is clinical in nature to person(s) identified in Section 2. If multiple names are listed in Section 2 and you wish to exclude name(s) from receiving addition information, write the excluded name(s) here:

_____

Alcohol or substance use information and/or records indicated below SA :
(Initial here)

☒ Treatment plan/EAP recommendations/After Care Plan

☒ Specific information regarding noncompliance/nonparticipation (e.g., missed appointments with treating provider, missed 12 step meetings, involuntary discharge from treatment program, etc.)

☐ Other: _____

Mental health information and/or records indicated below SA *(Initial here)*:

☒ Treatment plan/EAP recommendations

☒ Specific information regarding noncompliance/nonparticipation (e.g., missed appointments with treating provider, involuntary discharge from treatment program, etc.)

☐ Other: _____

HIV/AIDS related information and/or records SA *(Initial here)*

SECTION 4: Identify how long you would like this authorization to last:

This authorization shall be in force and effect for one year or until revoked by the undersigned, in the manner described below or until (insert expiration date or event) One Year (whichever is shorter).

SECTION 5: Your Rights:

You have a right to request a copy of this form and to request a copy of the information that is being disclosed. You do not have to sign this authorization and your refusal will not affect your benefits unless this authorization is necessary to determine your benefits. You have a right to revoke this authorization at any time by sending written notice to:

Beacon Health Options, Inc.
PO BOX 6065
Cypress, CA 90630-0065

Revoking this authorization will not have any effect on actions that Beacon Health Options, Inc. takes prior to receiving the notice of revocation. **The information disclosed by this authorization may be at risk for re-disclosure by the recipient and no longer protected by federal privacy laws.** Please note that if you have authorized the release of ONLY alcohol or substance abuse treatment records, you may revoke this authorization verbally. Revocation involving all other types of health care records must be in writing.

Sakinder Ali — 06/21/2021

Signature of the Individual — Date

SAKINDER ALI

Print Name