Authorization for Disclosure of Information

Employee Name:____

Employee Social Security Number:____

You have the right to refuse to sign this authorization. We will not withhold treatment, Medicaid benefits or payment processing if you refuse to sign the authorization. You will receive a copy of this signed authorization.

I authorize the designated staff at:___CAL Investments, Inc. DBA: Healthways Services____________

to disclose/use/receive the following protected information about me:___See checked below and will automatically renew annually from date below on pg. 2____
. (describe the specific types of information, including time period covered)

The designated staff may disclose to receive from: **potential and/or past employer's.** ________________________

The Specified Information Requested is:

( )Discharge Summary
( )Treatment Plan/Individual Work Plan
( )Verbal/Written Progress Notes
( )Psychiatric Evaluation
( )Physician's Order
( )Diagnosis and Evaluation(s)
( )Clinical Evaluation
( )Vocational Evaluation(s)
( )HIV related Info.
( )Psychological Evaluation
( )Education Records(s)
( )Substance Abuse Info.
( )Benefits Planning Query (BPQY)
( )Other "Specify"_**earnings information is needed to assist with maintaining gainful employment.**____

The disclosure/use is for the following purpose:

( ) to coordinate discharge planning/placement
( ) to assist in educational job placement
( ) at my request
( ) to assist in additional funding

( ) to discuss with my family the care and treatment I receive at:___________________________________

( ) Other: **employment information needs to be verified through copies of wage earnings from the Employer or Social Security Administration.**

If I am signing as a parent/guardian/managing conservator of a minor or guardian of the person of an adult. I understand the information disclosed/used/received may contain references to my family and myself.

I also authorize the disclosure/use/receipt of my *employment earnings or health information* regarding:

( ) Life Care Planning

( ) Domestic Violence Intervention

( ) Alcohol and Drug Treatment

( ) Anger Management Intervention treatment

( ) Vocational & Employment Services

( ) Medical Damages Assessment

( ) Durable Medical Equipment

( ) Disability Case Management

( ) Assistive Technology

( ) Earnings Capacity Evaluation

( ) Health Education & Disease Prevention

Note: I understand and agree that the information regarding my treatment and care may be requested from the referred agency or employer for the purpose of securing reimbursement for services rendered. This may include periodic audits of my records by insurance company, social security administration or state vocational rehabilitation agency or affiliated party.

These services will be evaluated annually and the disclosure of information agreement will be automatically renewed unless otherwise revised, case closure or terminated in writing by a Healthways Services representative.

____ _______________
(Individual) Date

____________________ ____________________ _______________
(Guardian/Representative, if any) (Relationship to Individual) Date

____________________ ____________________ _______________
(Healthways Representative Signature) (Print Name) Date