

FIRST SUN EAP ALLIANCE
2700 Middleburg Drive, Suite. 208, COLUMBIA, SC 29204

**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION
TO OR FROM FIRST SUN EAP ALLIANCE**

I, _____ do hereby authorize _____ to release to First Sun EAP
(Client or representative) (Releasing party and agency)

the following information: assessment and treatment recommendations, scheduled appointments and attendance, compliance with recommendations.

The above information is to be released for the following purpose: case management.

This authorization will expire on the following date: 1 yr from today unless revoked before that time.

INFORMATION ABOUT YOUR RIGHTS

I have read and understand the following statements about my rights:

- **I may revoke this authorization at any time** prior to its expiration date by notifying the releasing party in writing, but the revocation will not have any effect on any actions the releasing party took before it received the revocation.
- **I may review, obtain a copy, amend or see an accounting of disclosures** for any of the information requested here or in my record if I request such.
- **I am not required to sign this form** in order to receive services from First Sun EAP.
- I understand that if the person(s) or entity(ies) receiving the information is not a health care provider or health plan covered by federal privacy regulations, **the information described above may be redisclosed and is no longer protected by those regulations.** I have the right to seek assurances from the above-named recipients that they will not redisclose the above information to any other party without my further authorization.
- I am entitled to receive a copy of this authorization.

(Signature of Client)

(Date)

(Signature of Provider)

(Date)

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

PLEASE FAX BACK TO ME AT (803) 799-3772

THANK YOU