STATEMENT OF UNDERSTANDING AND CONSENT

The Mutual of Omaha Employee Assistance Program is a confidential assessment and referral resource provided for employees and their dependent family members. Included in the service is the opportunity for one or more face-to-face visits.In the event the assessment results in a recommendation for referral to a specialized provider or to a community resource, the Mutual of Omaha EAP professional can assist you in that process. Additional costs for services beyond those authorized by the EAP are the responsibility and obligation of the employee client and may or may not be covered by your health benefits plan. You may decline or discontinue these services and/or recommendations at any time.
CONFIDENTIALITY. All information that is obtained, discussed, and/or recorded during the EAP session will be maintained in confidential files. This information will remain confidential except for the following circumstances:

1. **When you request and provide written permission/consent for the release of specific disclosure;**
2. **The life or safety of yourself or others is seriously threatened;**
3. **Child abuse: The law requires that child abuse be reported;**
4. **EAP records are the subject of a court order (subpoena);**
5. **Other disclosures required by applicable law.**

ACKNOWLEDGEMENT/UNDERSTANDING. I have read and understand the above information relating to the confidentiality of the information discussed in the assessment. I also understand that I am not required to abide by the recommendations made following the assessment, that if I chose to follow those recommendations, this decision is to be made by me of my own free will.

Signature of Client (Guardian/if minor) _____ Date: _____

AUTHORIZATION OF RELEASE OF INFORMATION TO THE EAP OF MUTUAL OF OMAHA

I, (Client Name)_____authorize (Provider Name)_____

the following affiliate provider, to disclose personal information about me to Mutual of Omaha Employee Assistance Program, a service of Mutual of Omaha Insurance Company. The personal information that may be disclosed includes session dates, assessment and case summary, recommendations for care, and referral information. The purpose of the disclosure is for case management and the coordination or continuity of services. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain payment or my eligibility for benefits. Unless revoked earlier, this authorization will remain in effect for 12 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to the EAP of Mutual of Omaha. I realize that my right to revoke this authorization is limited to the extent that Mutual of Omaha Employee Assistance Program has taken action in reliance on the authorization and won't have any affect on any action they took before they received the revocation.
I understand that I am entitled to receive a copy of this signed authorization. I also understand that a copy of this authorization is as valid as the original.

(Signature)_____ (Date)_____

I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.