Comprehensive EAP

CONSENT FOR THE RELEASE OF INFORMATION
Comprehensive EAP, Inc.

I, _____, authorize_____
(Name of Person/Client) **(Name of Person/Organization Disclosing Information)**

To disclose to/obtain from _____
(Name of Person/Organization Receiving/Sharing Information)

The following information:

____ Attendance at the EAP
____ Participation in Treatment
____ Progress/Compliance with Treatment
____ Discharge Plan
____ Other Information as Specified _____
_____
_____
_____
_____

For the purpose of:

____ Assisting in Evaluation and/or Referral
____ Follow-up on a Referral
____ Informing Work Supervisor/HR Manager/Health Services
Of Treatment Participation
____ Other Information as Specified _____
_____
_____
_____
_____

The Release of Information will be valid for a period of 90 days from the date signed below.

I understand that by law I need not consent to this release of information; however, I choose to do so voluntarily for the purpose(s) specified above. I understand that I may revoke my consent at any time, except where the disclosure(s) has already been made.

_____ _____
Signature of Client/Participant **Signature of Witness**

_____ _____
Date **Date**