



Consent for the Release of Information

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