CONSENT TO RELEASE RECORD

I ____________________________, hereby authorize the EMPLOYEE ASSISTANCE PROGRAM to disclose records/information obtained in the course of services rendered to me, to: __________________________________________________________

The disclosure of records/information authorized herein is required for the following purpose:
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

and such disclosure shall be limited to the following specific types of information ("any/all information" is not sufficient, select one or more):

☐ Dates/attendance types of service          ☐ History & progress
☐ Demographic information                    ☐ Closing summary
☐ Intake summary                             ☐ Correspondence
☐ Other (specify): _________________________________

Within the scope of this consent, I give consent for any and all of the above designated information to be faxed to the person(s) or organization(s) named above.

This consent subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance hereon and if not earlier revoked, it shall terminate on ____________________________ (Date, event, or condition) without express revocation.

DATE _______________  CLIENT’S SIGNATURE _______________

DATE _______________  PARENT, GUARDIAN or AUTHORIZED REPRESENATIVE of CLIENT _______________

DATE _______________  PARENT, GUARDIAN or AUTHORIZED REPRESENATIVE of CLIENT _______________

CONFIDENTIAL CLIENT INFORMATION- Information may be released only in accordance with Title 42 Code of Federal Regulations, Part 2 and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")

Information used or disclosed pursuant to an authorization may be subject to disclosure by the recipient and no longer protected by the Federal Health Privacy Regulations.