

General Release of Information

I, _____, _____
(Name of Client) (Date of Birth)

(Address) (City) (State) (Zip)

authorize **Aurora Employee Assistance Program, 4067 N. 92nd St, Wauwatosa, WI, 53222** to release my/client's health information that may contain mental health, developmental disability and/or drug and alcohol abuse treatment information to:

(Name/Address/Program and/or Title)

☐ Check here if authorization is reciprocal (both the disclosing party and the recipient can mutually exchange information below).

Purpose: (Check all that apply)

- ☐ To report attendance at EAP assessment
- ☐ Treatment planning
- ☐ Further follow-up care
- ☐ Other (specify) _____

Information to be disclosed:

☐ Verbal ☐ Written

- ☐ Report attendance at EAP assessment & agreement to follow through
- ☐ Compliance with treatment recommendations and appointments
- ☐ Failure to comply with EAP recommendations
- ☐ Reports of progress and treatment
- ☐ Other (specify) _____

Dates of information to be disclosed: From _____ To _____

Expiration Date: This Release is good until the following date(s)/events: _____

If no date or event is specified, this Release will expire one (1) year from the date signed.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. I understand that I may be charged a fee for record copies. In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I am also aware that I may revoke this Authorization by notifying the Aurora EAP in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I realize that the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law.

I have had an opportunity to review and understand the content of this Release. By signing this Release, I am confirming that it accurately reflects my wishes.

Signature of Client

Date

Signature of Legal Representative

Date

If signed by a LEGAL REPRESENTATIVE, complete the following:

1. Individual is: ☐ a minor ☐ legally incompetent or incapacitated ☐ deceased
2. Legal authority: ☐ parent* ☐ legal guardian ☐ next of kin/executor of deceased ☐ activated POA for Health Care

* By signing above, I hereby declare that I have not been denied physical placement of this child