



Employee Assistance Program (EAP)
 Student and Family Assistance Program (SFAP)
 University Student Assistance Program (USAP)

P: 800.236.3231
 F: 414.760.5418
 EAP.LiveWellBeWell@aah.org

General Release of Information

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

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

authorize Advocate Aurora Employee Assistance Program 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)

- Attendance Reporting
- Compliance Reporting
- Other: (specify) _____
- Coordination of Care
- Personal (at my request)

Information to be disclosed:

- Dates of scheduled, attended, cancelled and/or missed appointments
- Recommendations, progress and/or follow through
- Clinical Notes
- Other (specify): _____

Dates of information to be disclosed: From: _____ To: _____

If left blank, only information from the past two years will be disclosed.

Expiration: If no date or event specified, this Release will expire one (1) year from the date signed. This authorization is good until the following date(s)/event: _____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: 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 Advocate Aurora EAP in writing. 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.

 Signature of Client or 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.