AdvocateAuroraHealth®

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

P: 800.236.3231
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eap@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.

IL Only- Witness signature for mental health/developmental disabilities records only: _____