Aurora Health Care®

Aurora Employee Assistance Program

4067 N. 92nd Street
Wauwatosa, WI 53222

T (800) 511-4804
F (414) 760-5418

2636 Eastern Ave
Plymouth, WI 53073

Student and Family Assistance Program - Release of Information

I, _____, _____
(Name of Parent/Client) *(Date of Birth)*

_____
(Address) *(City)* *(State)* *(Zip)*

authorize **Student and Family Assistance Program through Aurora EAP, 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)

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

Purpose: (Check all that apply)

X Coordination between the school and the Student and Family Assistance Program

☐ Treatment planning ☐ Follow-up care Other (specify) _____

Information to be disclosed: **X Verbal** ☐ Written

X Report attendance at Student and Family Assistance Program session(s)

☐ Treatment recommendations and appointments ☐ 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 Child over 14 , if being seen with 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

COPY TO CLIENT