EMPLOYEE RESOURCE SYSTEMS, INC.
GENERAL - RECIPROCAL RELEASE OF INFORMATION

I, (Name):_____ authorize the following EAP/MAP Counselor: _____at

Employee Resource Systems, Inc., 29 E. Madison, Suite 1600, Chicago, IL 60602. Phone:(312) 780-6316 Fax:(312) 269-0309

To release to, or receive from, any and all information/records regarding this client:_____

With this receiving Agency/Person & Address:_____

Specific Nature of Information to be released: _____

The following items must be initialed to be included in the use and/or disclosure of other health information:

_____ Mental Health Information ____Psychotherapy Notes ____Drug & Alcohol Treatment & Referral

For the purpose of:

- Facilitating mental health/alcohol and/or drug abuse treatment or continuity of care
- Facilitating social service referrals and resources
- Billing, payment, other financial matters including managed care issues
- Providing updates on client's progress and compliance with any recommendations
- Other: _____

This consent is valid until (calendar date required): _____

I understand that I have the right to inspect and copy the information to be disclosed and may revoke this authorization at anytime. Any such revocation will not affect materials disclosed prior to the revocation. The above-named person authorized to receive this information may use the information only for the purposes outlined above and may not redisclose it without my written authorization.

I also understand that if I refuse to consent to this release of information the following may occur: _____

_____

_____ _____ _____

Signature of minor 12 – 17 years inclusive | Signature of Client, Parent or Guardian | Date

_____ _____

Signature of Witness | Authorized Agency (Power of Atty is attached)

Under the provision of the Mental Health and Developmental Disabilities Confidentiality Act, HIPAA, and applicable Federal and State Alcohol and Substance Abuse Confidentiality Acts, there may not be redisclosure of any of the information provided pursuant to this release unless the patient, and/or parent of the patient who is a minor, specifically authorizes such disclosure. ***A separate release is required for psychotherapy notes.***

Revocation of Authorization

The undersigned hereby revokes the above authorization for disclosure.

_____ _____ _____

Signature of minor 12 – 17 years inclusive | Signature of Client, Parent or Guardian | Date

_____ _____

Signature of Witness | Authorized Agency (Power of Atty is attached)