



Aurora Health Care®

Aurora Employee Assistance Program

2500 N. Mayfair Road, Suite 630
Wauwatosa, WI 53226

T (800) 511-4804
F (414) 257-2256

2640 North 6th Street
Sheboygan, WI 53083

General Release of Information

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

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

authorize Aurora Employee Assistance Program, 2500 N. Mayfair Rd., Suite 630, Wauwatosa, WI, 53226 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 _____ (if left blank, information from the past year will be released)

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