

CONFIDENTIAL INFORMATION RELEASE AUTHORIZATION

Completion of this form authorizes the release of information described in the section below called "Specific Description of Records Authorized for Release". The person (record subject) whose records are released may have a right to inspect and, upon paying any applicable fees, obtain a copy of the disclosed records. Except for medication/somatic treatment records, a director/designee of a treatment facility for mental illness, developmental disability, alcohol or drug abuse may deny that right during treatment in some circumstances. Section 51.30, Wis. Stats., DHS 92.03-92.06 Wis. Adm. Code.

Name & Address – Agency / Organization I Authorize to Release Information

Ascension - Employer Solutions EAP
1820 Post Rd. Plover, WI, 54467
715-344-6379

1550 Midway Place, Menasha, WI 54952
920-720-1090

Name – Person Whose Records Will be Released (Record Subject)	
Address	
City, State, Zip Code	
Identifying Number (If Any)	Date of Birth
Name - Information May be Released To	
Organization	
Address	
City, State, Zip Code	

Specific Description of Records Authorized for Release (Include dates of records, if applicable)

- Dates of service
- Compliance
- Written or verbal summary of pertinent work-related information
- Written or verbal summary of client's work-related goals
- Recommendations
- Other:

Purpose or Need for Release of Information (Be Specific)

Collaboration to improve work performance / meet employer expectations

Understandings

- This authorization is voluntary. Refusal to sign will not affect treatment, payment, enrollment or benefits eligibility except for:
 - No exceptions
 - Exceptions (specify):
- The information that I authorize to be released may be redisclosed by the recipient of the records only if allowed by law. If information is redisclosed, the recipient of the redisclosed information may be controlled by different laws.
- I may revoke this authorization, in writing, at any time except for information already released as a result of this authorization. The written revocation must be given to the agency/organization I authorized to release information.
- Unless revoked, this authorization will remain in effect until the expiration time indicated below.

Choose One:

- Authorization expires as of _____ (Date).
- Authorization expires _____ month(s) from the date I sign this authorization.
- Authorization expires after the following action takes place:

As evidenced by my signature, I hereby authorize disclosure of records to the person(s) or agency(s) specified above.

SIGNATURE - Person Whose Records Will be Released (Record Subject)		Date Signed
SIGNATURE - Other Person Legally Authorized to Consent to Disclosure	Title or Relationship to Record Subject	Date Signed