NYS EMPLOYEE ASSISTANCE PROGRAM CONSENT FOR RELEASE OF INFORMATION See Reverse Side for Instructions	NAME: _____ DOB: _____

Part I - Consent To Release Information

Extent or Nature of Information to be Disclosed	
Purpose or Need for Information	
INFORMATION WILL BE RELEASED AND EXCHANGED BETWEEN THE FOLLOWING:	
Name: Title: Agency/Facility/Program:	Name: Title: Agency/Facility/Program:

I hereby authorize the *ONE TIME* release of the above information to the person/ organization/facility/program identified above. I understand that the information to be released is CONFIDENTIAL and the release to the entity identified does not authorize EAP to disclose the same information to any other entity without an additional consent form signed by me (see reverse side for exceptions). I understand that EAP is not prevented from clarifying information already given to the entity at a later date in order to ensure accuracy. I also understand that I have the right to cancel my permission to release information at any time by signing Part II on the reverse side of this forming the presence of the EAP Coordinator or Regional Representative.

My consent to release information will expire when acted upon, or 90 days from this date, whichever occurs first.

Signature of Employee/Person Acting For Employee	Relationship	Date Signed	Signature of EAP Coordinator / Representative	Date Signed

I hereby authorize the *PERIODIC* release of the above information to the person/organization/facility/program identified above as often as necessary to monitor participation in and successful completion of treatment and/or return to work. I understand the information to be released is CONFIDENTIAL. The release to the entity identified does not authorize EAP to disclose the same information to any other entity without an additional consent form signed by me (see reverse side for exceptions). I understand that EAP is not prevented from clarifying information already given to the entity at a later date in order to ensure accuracy**.** I also understand that I have the right to cancel my permission to release information at any time by signing Part II on the reverse side of this form in the presence of the *EAP Coordinator* ***or*** *Regional Representative.*

My consent to release information to the person/organization/facility/program identified above, will expire 90 days from date of signature unless said release is cancelled prior to that date as stipulated on reverse side. Continuation of release of <u>new</u> information beyond 90 days requires that a new Release Form be completed.

Signature of Employee/Person Acting For Employee	Relationship	Date Signed	Signature of EAP Coordinator / Representative	Date Signed

Part II B Cancellation / Refusal To Release Information

I hereby CANCEL my permission to release information indicated in Part I to the person/ organization/ facility/ program whose name and address is:	**I hereby REFUSE TO AUTHORIZE the release of information indicated in Part I to the person/ organization/ facility/ program whose name and address is:**

Signature of Employee/ Person acting for employee.	Relationship	Date Signed	Signature of EAP Coordinator / Representative	Date Signed

Use this space if additional room is needed to complete any of the items on the reverse side

INSTRUCTIONS

1. Employee signs A Y if the Release of Information is for a *SINGLE EVENT*.
2. Employee signs B Y if Information is to be Released *PERIODICALLY* during an episode of service.
3. If the client is under 18 years of age, only the responsible parent, relative, or guardian must sign.

EXCEPTIONS TO CONFIDENTIALITY

All information regarding EAP contacts other than as specified below will be kept strictly confidential.

1. Where information is required by law or executive order to be disclosed; or
2. Where there is reasonable belief that an employee=s conduct places him or her or another person in imminent threat of bodily harm; or
3. Where there is reasonable cause to suspect child abuse has been or will be committed.