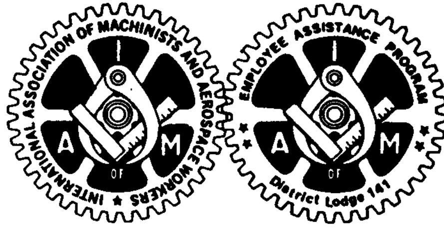

Authorization for Release of Information

I, ________________________________, do hereby consent to and authorize:
(name of person signing release)

____
(name of representative)

to disclose the following information:

____

____

____

This information will be disclosed to: ________________________________

____

The purpose and need for this disclosure is:

_______ Coordinate and monitor recommended treatment/services
_______ Assist in the follow-up after treatment/services
_______ Support family involvement
_______ Other: ____

I understand that I may revoke authorization for release of information at any time by notifying the above named agent in writing. This consent shall be in force for 1 year from the date signed, unless otherwise noted. I acknowledge that information released before revocation cannot be retrieved. I release the above named individual(s) and the International Association of Machinists Employee Assistance Program from any liability for disclosure of confidential information while this consent is effective.

____ Date__________________
(Signature) (day, month, year)

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