GUNDERSEN HEALTH SYSTEM
EMPLOYEE ASSISTANCE PROGRAM
CONSENT FOR RELEASE OF INFORMATION

I, ________________________(/ /), voluntarily consent to and authorize the following
(Please Print Name of Client) (DOB)
signed release(s) of information as needed:

- I understand this Consent is revocable at any time prior to the release of this information. This authorization will expire 120 days from the date signed.
- I understand that I have a right to inspect and receive a copy of the material to be disclosed under this Consent with reasonable notice.

SECTION ONE: Release by the Affiliate Provider to GHS-EAP (Each client must sign)

I authorize ________________________ to disclose and release to Gundersen Health Employee
(Print Name of Affiliate Provider)
Assistance Program (GHS-EAP), all information regarding assessment and treatment for purposes of billing and program monitoring.

Signature: ____ Date: ___________________________

SECTION TWO: Release to/from Providers

I authorize _______________________________________ to disclose to and/or receive from
(Print Name)
____ the following information:
(Print Name)

____
____

The purpose or need for this disclosure is:

____
____

Signature: ____ Date: ____________________

SECTION THREE: Release to Employer

I authorize Affiliate Provider/GHS-EAP to disclose and release to representatives of my employer, ____ the following information:
(Print Employer/Representative)

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The purpose or need for this disclosure is:

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Signature: ____ Date: _________________________