

COPE

incorporated

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AUTHORIZATION TO RELEASE INFORMATION

(Client's Name)

(Counselor's Name)

1. Name of person or client making disclosures and requesting information:

(Employee Assistance Program)

2. Name of persons or organizations to whom disclosure will be made and/or with whom information will be exchanged:

3. Purpose or need for the disclosure:

4. Extent and nature of information to be exchanged:

5. Permission is granted until _____

(Date or event on which release will expire)

- *I understand that confidential information concerning me cannot be disclosed without my written consent and that I may revoke this consent at any time, in writing, except to the extent that action has been taken previous to my revocation.*
- *I understand that the EAP cannot guarantee that the party to whom the information is being released will keep the information confidential, and if re-disclosure occurs, the information may not be protected by federal law.*
- *I understand that COPE will not condition the provision of services on my signing of this authorization.*

(Signature of Client)

(Date Signed)

(Signature of Witness)

(Date Signed)