Solution Resources EAP LLC
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Authorization for the Release of Information

The undersigned hereby authorize my provider at Solution Resources EAP, LLC, to exchange information regarding ______________________________ with the following service provider:
(client's name)

____

____

The following information may be released or obtained (check):

☐ All pertinent information
☐ Demographic Data
☐ Academic/psychological Tests
☐ Mental Health Treatment Notes/Summaries
☐ Substance Abuse Treatment Notes
☐ Medical Information
☐ Psychosocial History
☐ Behavioral Reports
☐ Assessment Results
☐ Psychiatric Evaluation
☐ Assessment summary, recommendations and participation in treatment
☐ Other ____

I/we are aware that the information to be exchanged may contain information about mental health and substance abuse issues. The information may be exchanged verbally, in writing (letter or dedicated fax) or by email for the purposes of

☐ assessment ☐ referral ☐ coordination of services ☐ employer contact

This Consent will remain valid ☐ until discharge from services
☐ until ______________________________.

If neither of the above boxes is checked, this Authorization is valid for 90 days from the date of signature. Clients may revoke this Authorization in writing at any time.

______________________________ Date:____________________ (**if client under the age of 16)
Signature of Parent/Legal Guardian**

______________________________ Date:____________________
Signature of Client

______________________________ Date:____________________
Signature of Client

______________________________ Date:____________________

Witness