



HEALTH AND HUMAN SERVICES GROUP
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PLEASE TYPE OR PRINT CLEARLY

DEA EMPLOYEE ASSISTANCE PROGRAM
CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Case Number: _____

I _____, authorize _____
(EAP Participant) (Name & Title of Person/Designation of Program)

To disclose to: _____
(Name/Title of Person or Organization)

The following information: _____

The purpose of the disclosure authorized by this Release is to: (Purpose of Disclosure, as specific as possible)

I understand that my records are protected under the Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that, in any event this consent expires automatically as follows (Specific date, event, or condition upon which this consent expires)

(Signature of Participant)

(Date)