

EMPLOYEE RESOURCE SYSTEMS, INC.
RECIPROCAL RELEASE OF INFORMATION

Name:	
Address:	
Social Security #:	Date of Birth:

I, _____ authorize _____ or designate at **ERS, Inc.**
Client name EAP/MAP Counselor

Address: Employee Resource Systems, Inc., 29 E. Madison, Suite 1600, Chicago, IL 60602
Phone: (312) 780-6316 Fax: (312) 780-6344

To exchange information with: _____

Type of Information to be released: _____

Purpose: _____

NOTICE TO RECEIVING AGENCY/PERSON: State and Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2 or the Illinois Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/1 et. seq.)

I understand that:

- 1- This consent will automatically expire one year from date signed **or on the following date:**_____.
- 2- I have the right to inspect and copy the information to be disclosed. I will be given a copy of this authorization for my records.
- 3- I may revoke this consent at any time by giving written notice to the EAP/MAP counselor designated above.
- 4- Failure to sign this release of information will have the following consequences: _____

Signature of Client Date

Signature of Parent, Guardian, or Personal Representative Date
(If you are signing as a personal representative, describe your authority to act for this individual – power of attorney, etc.)

_____ Check here if client refuses to sign authorization.

Signature of Witness Date



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