EMPLOYEE ASSISTANCE PROGRAM
AUTHORIZATION FOR RELEASE OF INFORMATION
CHICAGO POLICE DEPARTMENT

Client Name:______________________________ D.O.B.____________________

I, ____ authorize
(Patient /parent or guardian of child < 18 years)

Employee Assistance Program **1759 West Adams, Chicago, IL 60612**
(Facility/Person) (Address)

to release information relating to my health care and any services I have received to:

Chicago Police Department
(Agency)

3510 South Michigan, Chicago, IL 60653
(Address)

____________________ ____________________
(Telephone) (Fax, if applicable)

The information to be disclosed shall include:

- ☐ Attendance at EAP ☐ Participation at EAP ☐ Release from EAP
- ☐ Information for the following dates of treatment:____________________
- ☐ Specific information to Employer: ____________________

Other instructions:____________________

I understand that if I so indicate below, this information may include the following:

- ☐ Mental Health Treatment ☐ Drug Treatment/Evaluation ☐ Other (Specify)
- ☐ Alcohol Treatment ☐ Domestic Violence History ____________________

The information shall be used for the purpose of -____________________

This authorization is valid until____________________

I understand that: I have the right to revoke this authorization in writing at any time. Revoking this authorization shall have no effect on disclosures made before the withdrawal of the authorization. The Chicago Police Department may not condition treatment on this authorization or my refusal to sign such authorization. The information disclosed pursuant to the authorization may be subject to re-disclosure by the recipient.

____________________ ____________________
Signature of Patient (Date)

____________________ ____________________
Signature of Personal Representative (if applicable) (Date)

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Personal Representative relationship to individual (i.e., authority to act on individual's behalf)

CPD-62.482 (2/18)