TRAUMATIC INCIDENT STRESS MANAGEMENT PROGRAM
AUTHORIZATION FOR STATUS RELEASE

CHICAGO POLICE DEPARTMENT

Client Name:_____ D.O.B._____

I,_____ authorize
(Department Member)

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

to release my status regarding the Traumatic Incident Stress Management Program to the

Chicago Police Department
(Agency)

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 Department Member) (Date)