



Family Service of the Chautauqua Region
 332 East Fourth Street, Jamestown, NY 14701 (716) 488-1971 fax (716) 483-6878
 Email: familyservice@fscr.mygbiz.com

RELEASE OF INFORMATION

Date: _____

Expiration Date: _____
 12 months after inception

Employee's Name: _____

I hereby authorize _____ to release and receive
Provider of Service
 information regarding my participation in the Employee Assistance Program (EAP)
 to:

Family Service of the Chautauqua Region Employee Assistance Program

I understand that this release of information gives the above designated Provider of Service permission to report pertinent information regarding my utilization of the EAP to Family Service of the Chautauqua Region only. This information is necessary for billing/reimbursement purposes and utilization data. I also understand that I can withdraw this Consent for Release of Information at any time.

 Employee's Signature

 Date

 Referring Supervisor's Signature

 Date