

Family Service of the Chautauqua Region, Inc.
332 East Fourth Street, Jamestown, New York 14701
Phone: (716) 488-1971, Fax: (716) 488-9198

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 Services of the Chautauqua Region, Inc. 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 Services EAP 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 anytime.

Employee's Signature

Date

Provider's Signature

Date