

**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 Family Service of the Chautauqua Region to release and receive  
Provider of Service  
information regarding my participation in the Employee Assistance Program (EAP) to:

**Company:** \_\_\_\_\_

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**