Employer/Health Plan: _____

INTEGRATED BEHAVIORAL HEALTH

PO Box 30018, Laguna Niguel, CA, 92607-0018 • (800) 395-1616 • Fax (714) 556-5430

EMPLOYEE ASSISTANCE PROGRAM
AUTHORIZATION TO RELEASE INFORMATION

A. I, _____, hereby authorize contact between IBH and:
(Client's Name)

AGENCY/PROFESSIONAL	CITY	PHONE NUMBER
_____	_____	_____
_____	_____	_____
_____	_____	_____

to facilitate referral for treatment and to verify my admission, attendance, general progress and discharge status throughout the treatment process.

_____ _____
Client *Witness to Signature*

_____ _____
Date *Date*

B. I, _____, further authorize IBH to confirm my status, attendance and general progress in following through with my program recommendations. This confirmation may be made to the following individuals(s) in order to facilitate resolution of my problems:

NAME	RELATIONSHIP	PHONE NUMBER
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____
Client *Witness to Signature*

_____ _____
Date *Date*

I understand that I can revoke this consent at any time, except to the extent that action has been taken in reliance of this consent prior to my revocation. I understand that this authorization will expire two years after the date of my signature, or, if not earlier revoked, it shall terminate on:

_____
(Event, Date, or Condition)