

**EMPLOYEE RESOURCE SYSTEMS, INC.**  
RECIPROCAL RELEASE OF INFORMATION

Name:	
Address:	
Social Security #:	Date of Birth:

I, \_\_\_\_\_ authorize \_\_\_\_\_ or designate at **ERS, Inc.**  
Client name EAP Counselor

Address: **Employee Resource Systems, Inc., 29 E. Madison, Suite 1600, Chicago, IL 60602**  
Phone: **Phone: (312) 780-6316 Fax: (312) 780-6344**

to exchange information with: \_\_\_\_\_

Type of Information to be Released: \_\_\_\_\_

Purpose: \_\_\_\_\_

NOTICE TO RECEIVING AGENCY/PERSON: State and Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2 or the Illinois Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/1 et. seq.)

I understand that I may revoke this consent at any time by giving written notice to the EAP counselor designated above. If no prior notice of revocation is received, this consent will automatically expire on this date: \_\_\_\_\_  
(one year from date signed)

I understand that I have the right to inspect and copy the information to be disclosed. I will be given a copy of this authorization for my records.

I also understand that failure to sign this release of information will not affect my treatment but may have the following consequences:

\_\_\_\_\_

\_\_\_\_\_  
Signature of Client Date

\_\_\_\_\_  
Signature of Parent, Guardian, or Personal Representative Date

(If you are signing as a personal representative, describe your authority to act for this individual – power of attorney, etc.)

\_\_\_\_\_ Check here if client refuses to sign authorization.

\_\_\_\_\_  
Signature of Witness Date

