EPRA
Opening a Door to a New Begining

CONSENT FOR RELEASE OF INFORMATION CONCERNING ALCOHOLISM/DRUG ABUSE PATIENT

Prepare an original/ or the Patient 's Case Record If this form is sent to another agency with a request for information, prepare a copy, and maintain the original in the Patient's Case Record

Patient Name:

DISCLOSURE WITH PATIENT'S CONSENT

I, the undersigned, give permission for _____
TREATMENT PROGRAM& ADDRESS
to disclose information about my treatment and recovery, including diagnosis, work history, functional limitations, progress in treatment, public assistance status and employment preparation services received to EPRA for the purpose of receiving job placement services. (Vocational Program).
The above named Vocational Program to re-disclose my name, employment history, job skills and abilities to potential employers and to receive employment related information from my employers for the purpose of assisting me in obtaining and maintaining employment.

The above named Vocational Program to re-disclose to the New York State Office of Alcoholism and Substance Abuse Services (OASAS) any and all information about me in its possession, including but not limited to, the name of my employer, the number of hours per week worked, and wages for the purpose of auditing and evaluating the performance of the Vocational Program.

I, the undersigned have read the above and authorize the staff of the disclosing facility named to disclose such information as herein contained. I understand that this consent maybe withdrawn by me at any time except to the extent that action has been taken in reliance upon it. This consent shall expire six (6) months from its signing, unless a different time period, event, or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records and that re-disclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part.

ONE (1) YEAR FROM THE DATE OF EMPLOYMENT

TIME PERIOD, EVENT OR CONDITION REPLACING PERIOD SPECIFIED ABOVE:

_____

NAME OF PATIENT | SIGNATURE | DATE

EMPLOYMENT PROGRAM FOR RECOVERED ALCOHOLICS INC

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