EMPLOYMENT RESOURCES, INC.
2701 International Lane, Suite 210 | Madison, WI 53704 | eri@eri-wi.org email
608-246-3444 phone | 855-401-8549 toll-free | 608-246-3445 fax
www.eri-wi.org

Authorization for Release of Confidential Information

Date:

CLIENT PROFILE

Regarding the records of: _____
Last Name First Name Middle Name

Date of Birth: _____ Social Security Number: ___ - ___ - ____
(MM/DD/YYYY)

AUTHORIZED AGENT OR ORGANIZATION

Agency: _____ FAX: ( ) -

Address: _____
Street City State Zip

AUTHORIZATION

I authorize the above named organization to ☒ disclose to and/or ☒ obtain from Employment Resources, Inc. (ERI), the following information from my records, including information about mental health (§ 51.30), alcohol and drug use/abuse (§ 93.282), HIV/AIDS test results, and developmental disabilities (send all information checked):

General Information

- ☐ Medical Records
- ☐ Educational Records, including transcripts
- ☐ Mental Health Records
- ☐ Employment Records
- ☐ Admission and Discharge Reports
- ☐ Vocational Evaluations
- ☐ Other (specify): _____

Benefits Information

- ☐ SSI/SSDI
- ☐ Medicare/Medicaid
- ☐ County Economic Support
- ☐ Other (specify): _____

The purpose for this disclosure is to gather information for ERI Benefits Counseling Services.
This authorization can be revoked at any time prior to the expiration date, except for that information already released with consent, which may continue to be used to complete action already taken. If you wish to revoke this authorization you must do so by writing to both ERI and the other agency or person listed on this form. You do not have to sign this authorization in order to receive services from the parties listed on this form. If the organization(s) and/or person(s) listed on this form are not subject to federal health privacy laws, the information they receive may lose its protection under those laws and thus be re-released without your permission.

This authorization expires **12 months** from today's date on: _____

Signature of Individual: _____ Date: _____

OR Signature of Person Legally Authorized to Sign on Individual's Behalf:

_____ Relationship to individual**:** _____