This is a fill-in form. Please click on the appropriate area to enter information. Tab between fields and PRINT when completed.

STATE OF WISCONSIN
DEPARTMENT OF ADMINISTRATION
DIVISION OF PERSONNEL MANAGEMENT
DOA-15703 (C06/2015)
Authority: Executive Order, "Establishment of an Employee Assistance Program" October 1, 2003
PREVIOUSLY OSER-EAP-15

RETURN TO:
EMPLOYEE ASSISTANCE PROGRAM
101 E. WILSON ST, 4TH FL
MADISON, WI 53703

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

A. Individual Who is Subject of Record	**B. Person/Organization Being Authorized to Release**
Name	Name/Title
Address	Organization
	Address/Phone
Phone	

C. I hereby authorize the Employee Assistance Program (or other person or organization identified
The purpose or need for such disclosure is:

D. Information may only be released to the following individual:	
Name/Title	Address
Organization	Phone

E. I hereby authorize the disclosure of my records and information about me as specified above which may not be used by or shared for the benefit of any other party.

I understand that I may revoke this authorization, in writing, at any time except where information has already been released as a result of this authorization. Unless revoked, this authorization will remain in effect until the expiration time I have indicated:

☐ Authorization expires as of _____(date).

☐ Authorization expires after the following action takes place:

Signature of Individual Who is Subject of Record _____

Date _____ Witness of Signature _____

Print Form Clear Form