

**CONSENT TO THE RELEASE OF MEDICAL AND OTHER INFORMATION
CONCERNING TREATMENT FOR ADDICTIVE DISORDER**

(To be completed prior to or at the time of collection of the employee's specimen, if possible.)

I hereby request that my Employee Assistance Plan counselors, physicians, psychiatrists, psychologists, addictionologists, drug or alcohol addiction treatment counselors (hereinafter referred to as "EAP providers") provide such information about my diagnosis and treatment as is requested by my employer, Tift County, through its Personnel Director or County Administrator.

I understand that such information may include the nature and severity of the addiction, my prognosis for successful treatment, the requirements for successful treatment, my compliance with all treatment requirements, and my progress in the treatment program.

I understand that the purpose of providing the information is to enable my employer to determine that I am in complete compliance with all requirements of my treatment program as prescribed by my EAP providers.

Employee Signature

Date

Printed Employee Name

Witness

Date