

Employee Name: _____

Employee SS#: _____ DOB: _____

Company Name: _____ Dept. _____

Work Phone: _____ Home Phone: _____

Job Classification: *Circle:* Management or Non-Management

Years with Company: _____ *Circle:* Full Time or Part Time

Briefly describe the reason for referral: _____

LIMITED CONSENT FOR RELEASE OF INFORMATION

Please read and sign below:

I understand that I have been referred to Parkview EAP. I authorize Parkview Employee Assistance Program to release information regarding **my attendance** at the required session(s) with the EAP counselor to referring management. **No other information will be released without additional consent.**

Employee Printed Name: _____ Date: _____

Employee Signature: _____

Manager Printed Name: _____ Date: _____

Manager Signature: _____ Phone Number: _____

(Upon completion of this form, please FAX the form to the EAP office at (260) 484-9851