

## Mandatory Referral and Release Form **EMPLOYEE INFORMATION**

Employee Name:	
Employee SS#:	DOB:
Company Name:	Dept
Work Phone:	Home Phone:
Job Classification: Circle:	Management or Non-Management
Years with Company:	<i>Circle</i> : 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 <i>my attendance</i> at the required session(s) with the EAP	
counselor to referring management. No other information will be released without additional	
<u>consent.</u>	
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