



Employee Assistance Program Release of Information

Employee Name *(print)* _____

Work location/ Department _____

Home address _____

Phone (C) _____ (W) _____ e-Mail _____

Referred by *(print name)* _____ *(print job title)* _____

I understand the information I share with the Employee Assistance counselor is confidential and will not be entered into my employee file under any circumstances. I understand my rights to confidentiality: The Employee Assistance Program counselor cannot identify that I have requested a meeting without my written consent. I understand that if I present to the Employee Assistance Program counselor with evidence of or a threat to myself or a threat of harm to someone else, the Employee Assistance counselor must report these behaviors to the proper authorities. *(initial here)* _____

Please be advised that if your supervisor has referred you for Employee Assistance services, the only information that can be shared is:

- Employee has been compliant with attending his/her appointments.
- Employee has used appropriate rescheduling procedures, if needed.
- Employee was referred to an outside provider and has been compliant in attending those appointments.

Release of Information to an outside agency:

I _____, DOB _____, Other _____

authorize Las Cruces Public Schools Employee Assistance Program Services to obtain from/provide to

_____ Address _____

Phone number _____ Fax _____

the following information pertaining to me: _____

This consent may be revoked by me at any time, but may not be revoked with respect to information provided or actions by Las Cruces Public Schools prior to the time of revocation. This consent expires one year from the date signed below, unless otherwise noted below.

Signature of Employee _____ Date _____

Signature of EAP Counselor _____ Date _____