



Manager Assist Line: 1-877-249-4751  
Please return this completed and signed form via  
E-mail: ManagerConsult@DeerOaks.com or fax: 1-866-240-3933

Date of Referral: \_\_\_\_\_

**EMPLOYEE INFORMATION:**

Employee Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: Male / Female

Address: \_\_\_\_\_

Cell or Home number: \_\_\_\_\_ Can a message be left on voicemail? Yes / No

Work number: \_\_\_\_\_ Can a message be left on voicemail? Yes / No

Email: \_\_\_\_\_

Employee's position: \_\_\_\_\_ Department: \_\_\_\_\_

Current Employment Status (e.g., working, suspended, on paid or unpaid leave etc.): \_\_\_\_\_

**COMPANY AND REFERRING MANAGER DETAILS:**

Company Name: \_\_\_\_\_

1-Manager/HR Name: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Preferred forms of communication? Email: Yes / No Telephone: Yes / No Voicemail: Yes / No

2-Manager/HR Name: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Preferred forms of communication? Email: Yes / No Telephone: Yes / No Voicemail: Yes / No

Reason for the referral: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## AUTHORIZATION TO RELEASE/RECEIVE INFORMATION

I, \_\_\_\_\_, hereby authorize **Deer Oaks EAP**  
(Client's Name)

**Services** to release / receive information contained in my case records subject to the conditions below.

1. The name of the person(s), title, organization(s) to whom disclosure is to be made is (list each person):  
\_\_\_\_\_
  
2. The specific information **Deer Oaks EAP Services** is authorized to release / receive is\*:
  - Scheduled appointments and attendance
  - Compliance with EAP session treatment recommendations
  - Referral to outside resources to address the problem where appropriate
  - After-care recommendations where appropriate
  - DOT/SAP:** For referrals that include substance use issues, does the employee fall under the scope of the Federal DOT, and will therefore require a DOT/SAP evaluation?  
*\*(Manager Referrals are not intended to provide the following: Fitness for Duty or Return to Work performance assessments.)*
  
3. The purpose of the disclosure I am authorizing is:
  - To facilitate a referral for counseling
  - To provide feedback regarding my contact and participation with **Deer Oaks EAP Services**
  
4. I understand that this consent is subject to revocation in writing by me at any time except to the extent that **Deer Oaks EAP Services** has already taken action in reliance on this consent. If not previously revoked, the consent will terminate automatically upon **Deer Oaks EAP Services** designating that services are completed or one year from today's date (whichever comes first).
  
5. I understand that once information is released it is no longer within the control of **Deer Oaks EAP Services**, and there is the potential for re-disclosure by the recipient.
  
6. I understand that my decision to sign this authorization is voluntary. I understand that my decision not to provide authorization may result in **Deer Oaks EAP Services** being unable to provide any or all of its services.

Client's Name:  
(Please print) \_\_\_\_\_

Manager/HR  
Name:  
(Please print) \_\_\_\_\_

Signature of  
Client: \_\_\_\_\_

Signature of  
Manager/HR: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_