



Counseling & Family Resources, Ltd.
EAP Preferred
Employee Assistance Services
Behavioral Health Services
2700 North 3rd Street, Suite 2008
Phoenix, Arizona 85004-4602
602-264-4600

Supervisory/ Management Referral Release of Information

Name of Company (*Please Print*): _____

Company Address: _____

I, _____, understand that I am being referred to
(*Name of Employee*)

EAP Preferred due to _____

I understand that I must contact EAP Preferred at 602-264-4600 within _____ hours/days to schedule an appointment for an assessment. I acknowledge this information as discussed with my supervisor or personnel liaison.

I authorize the release of the following information to:

Name of Referring Supervisor or Personnel Liaison (*Please Print*)

Phone Number(s) (Supervisor/Manager/Personnel Liaison)

1. Scheduled appointments and attendance
2. Compliant with treatment recommendation
3. Termination of treatment

I understand that this referral is part of an effort to improve job performance and/or attendance. I further understand that my return to work (if applicable) depends on successful completion of the recommended treatment plan by EAP Preferred, and I shall comply with all other requirements of my company's policy and procedures.

Signature (Employee) (*Print Name also*)

Date Signed by Employee

Signature of Supervisor (Employer) (*Print Name also*)

Date Signed by Employer

**Copy is faxed to EAP Preferred PRIOR TO FIRST VISIT at 602-264-7325,
Attn: Roseanne Boyle or Maggie Winter.**

