Employee Assistance Program

CONSENT TO DISCLOSE INFORMATION TO SUPERVISOR

Employee#: _____

Division/Department: _____

Supervisor: _____

I, _____, give permission to the LLBO
(*Employee name)*
Employee Assistance Program representative to share the following information with

_____, and/or_____.
(Supervisor Name) (Department Management)

Only the information indicated below shall be shared:

☐_____

☐_____

☐_____

_____ _____
Employee Signature/Date *EAP Signature/Date*

Print Form

This form will be void after 60 days or if the employee stops authorization by written contact to EAP personnel*