# Authorization to Disclose Information

I, _____, DOB:_____
**(Print name in full)**

of _____
**(Full address)**

consent to the exchange of information between

_____
**(LifeWorks by Morneau Shepell EAP - Counselor's Name/Practice Name)**

and _____
**(Name of Facility, Agency, or Individual)**

I understand that any such professional consultation will be to assess my needs or those of my dependent, as well as to assist in initiation, coordination, and follow-up on any counseling plan that may be formulated.

I understand that any discussion or documentation exchanged will be held in confidence by both parties and will become part of the Clinical Record.

The Authorization to Disclose Information will expire one (1) year from the date signed below. The client may verbally withdraw this Authorization at any time prior to the expiration date.

**Please Note: No information, even with a signed release, can be shared with an employer. Further, EAP Counselors may not make any recommendations/diagnoses pertaining to medical leave/FMLA, workman's compensation, or fitness for duty.**

_____ _____
Client's Signature (or parent/guardian's signature) Date

_____ _____
Witness Date