

Authority to Release Client File Notes Request Form

CLIENT REF: _____

To: _____

From: (enter name in full) _____

Address: _____

Telephone: _____ Mobile: _____ Email: _____

Signature: _____ Date: _____

I, _____, hereby authorise _____
(enter your name in full) (enter the name of the EAP Professional that provided support)
to release to EAP Services Limited, file notes for sessions attended by me between _____ and _____
(enter date dd/mm/yyyy) (enter date dd/mm/yyyy)

WITNESS

Name: (enter name in full) _____

Address: _____

Signature: _____ Date: _____

Please sign and return by email to our Clinical Services Team - cst@eapservices.co.nz