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0800 SELFHELP (0800 735 343)

CONSENT TO RELEASE INFORMATION

Date: _____/_____/_____

Name of client: _____

Name of organisation: _____

Name of counsellor: _____

This is to certify that I formally give permission for my EAP counsellor to provide a Raise Ltd Wellness Specialist and/or a Raise Ltd Director relevant information/feedback regarding the following details:

_____

_____

_____

_____

This informed consent is valid for (select one of the following):

☐ 90 days from date on this consent ☐ The duration of my appointment/process

and can be revoked by me at any time.

Signed:

Client: _____

Witness: _____

Please attach a copy of client's ID with signature as proof of identity, e.g., driver licence, passport, student ID.