DZ Counseling/ Daniel Zykorie, LLC
Counseling and Neurofeedback Training
Children, Adolescent, Adults Couples & Families
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Daniel Zykorie, MSW, LCSW-S
Cathy Ielpi, MA, LPC
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Client Authorization to Release/Receive Confidential Information

Client's full name: _____ **Client's date of birth:** _____

Counselor's Name: _____

AUTHORIZATION GRANTS THE FOLLOWONG PERSON(S) TO: (Please Check All that Apply)

☐ ACCESS MY CLIENT PORTAL

☐ COMPLETE MY FORMS AND DOCUMENTS

☐ MAKE PAYMENTS/ACCESS PAYMENT INFORMATION

☐ CONSULT WITH MY HEALTH CARE PROVIDER OR EDUCATOR

☐ RELEASE/RECEIVE CONFIDENTIAL INFORMATION-RECORDS TO/FROM THOSE SPECIFIED BELOW

I authorize my counselor and the following person/agency/facility/school to function as circled above and described below on my behalf:

Full Name, Title, Contact Information, Relationship to Client, and any Limitations of your consent:

_____

_____

_____

My signature indicates my authorization and consent of counselor to share and/or receive confidential information or the permission of identified persons/others to perform above specified actions on my behalf.

_____ _____ _____

Client's Name (14 yrs. and older) Date Client's Signature

If client is under the age of 18, Parent must sign:

_____ _____ _____

Parent's/Legal Guardian's Name Date Parent's/Legal Guardian's Signature

****This Authorization will expire one year from date signed or when expressly (written) terminated by Client or Client's Parent/Legal Guardian (if under 14 yrs.) or 60 days following last date of service at DZ Counseling/Daniel Zykorie, LLC**