GREGORY STRUVE, LAC
AUTHORIZATION FOR COLLATERAL THERAPEUTIC INVOLVEMENT

Client Name: ____ Date of Birth: _____________

I hereby authorize (name of client's guest): _______________________________________ to participant

in my therapeutic sessions with my therapist (therapist's name): ________________________________,

for the general purpose of assisting me in achieving my therapeutic goals. As the guest of the client I

acknowledge the following.

a. All information discussed during the session and any subsequent sessions is to be held in the utmost confidentiality in perpetuity.
b. Participating in a session or sessions does not make you, the guest, a client of Maria Struve, LPC.
c. Participating in a session or sessions does not authorize you to have access to the client's medical record.

I, the client, understand and acknowledge, that the guest is solely responsible to make every reasonable effort to maintain the client's confidentiality. Maria Struve, LPC cannot in any way be held responsible if the guest breaks the client's confidentiality.

____ ___________________
Patient Signature Date

____ ___________________
Parent/Guardian Signature Date

____ ___________________
Client Guest Date

____ ___________________
Witness/Therapist Date