

# ***Certified Rehabilitation Services***

**Darlene J Fittizzi-Tanski, M.S., CRC**

*An Approved Ticket to Work Employment Network*

Hours by Appointment  
Darlene@Certifiedrehabservices.com

Office 518-458-2773  
Fax 518-458-9402  
Toll free 1-877-465-WORK (9675)

## ***CONSENT / RELEASE FORM***

\*\*\*\*\* Release of information TO *Darlene Fittizzi-Tanski, M.S., CRC* \*\*\*\*\*

I hereby authorize *my employer, present or future, its Department of Human Resources, Payroll Department or Comptroller, and/or Equifax Work Number* to release to:

***Darlene Fittizzi-Tanski, M.S., CRC, d/b/a Certified Rehabilitation Services, and/or their representatives,***

Any payroll records or documents requested, in all forms and formats (paper, electronic, telephonic, facsimile, and email, to include online access) for the purpose of income verification.

I understand that all such documents and information will be treated as confidential and, unless otherwise specified, used only for the purpose of providing for and administering rehabilitation counseling services. This consent covers periodic release of information to referral and treatment agencies, whether written, verbal, audio, electronic or otherwise, unless specifically limited as noted above. It is further understood that my consent for release of information may be rescinded at any time by written notice given to Darlene Fittizzi-Tanski, M.S., CRC or her representatives. This consent will be valid only for the period of one year from the date signed below.

Marylou Poole  
(participant name - printed)

Marylou Poole  
(participant signature)

Darlene Fittizzi-Tanski, M.S., CRC

(date)

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## CONSENT / RELEASE FORM

\*\*\*\*\* Release of Information FROM *Darlene Fittizzi-Tanski, M.S., CRC* \*\*\*\*\*

I hereby authorize *Darlene Fittizzi-Tanski, M.S., CRC* and/or her representative, to release to;  
*New York State ACCES-VR Counselors, staff and potential/present employers.*

the following documents in all formats (paper, electronic, telephonic, facsimile, and email/online) and/or information; (specify information and note any limitations)

*Disability related information as it pertains to Vocational Services (Job Placement Assistance and Advocacy) including employment, educational and legal/criminal histories.*

\*\*\*\*\* Release of information TO *Darlene Fittizzi-Tanski, M.S., CRC* \*\*\*\*\*

I hereby authorize *New York State ACCES-VR counselors, staff and prospective/present employers.*  
to release to *Darlene Fittizzi-Tanski, M.S., CRC,* and/or her representatives,

(individual or agency name)

the following documents or information in all formats (paper, electronic, telephonic, facsimile, and email/online);

*Disability related information as it pertains to Vocational Services (Job Placement Assistance and Advocacy) including employment, educational and legal/criminal histories and pay rate/salary.*

I understand that all such documents and information will be treated as confidential and, unless otherwise specified, used only for the purpose of providing for and administering rehabilitation counseling services. This consent covers periodic release of information to referral and treatment agencies, whether written, verbal, audio, electronic or otherwise, unless specifically limited as noted above. It is further understood that my consent for release of information may be rescinded at any time by written notice given to Darlene Fittizzi-Tanski, M.S., CRC or her representatives. This consent will be valid only for the period of one year from the date signed below.

*Marjion Poole*  
(consumer name - printed)

*Marjion Poole*  
(consumer signature)

\_\_\_\_\_  
Darlene Fittizzi-Tanski, M.S., CRC

\_\_\_\_\_  
(date)

\_\_\_\_\_  
(consumer soc #)