Diane Byster, LMFT, NCC, RYT
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AUTHORIZATION TO RELEASE INFORMATION

I, _____, hereby authorize an exchange of verbal, recorded, and/or written information between Diane Byster, LMFT and:

Name: _____

Address: _____

_____

Phone Number: _____

for the purpose of _____

_____.

This authorization will expire on _____, or if this line is left blank, one year from date of signature below.

In addition, I may revoke this authorization in writing at any time, except to the extent that action has already been taken.

_____ _____
Client's Signature Print Name Here

_____ _____
Client's Signature Print Name Here

_____
Date Signed

_____ Diane Byster
Therapist's Signature