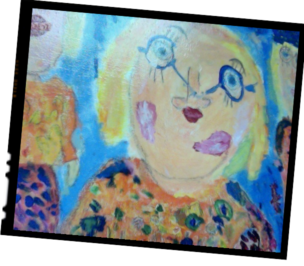

Lyla Tyler MFT

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AUTHORIZATION FOR EXCHANGE OF INFORMATION

I hereby give permission for the following person/agency to mutually exchange/release counseling-related information to Lyla Tyler, MFT, RPT-S.

____

Date

____

Agency or Name

____

Mailing Address City State Zip

____

Phone Number

____

Client's Name

____

Parent's Name (if client is under 18)

____

Address City State Zip

____

Signature (client, parent or guardian)