Family Therapy & Wellness
Institute of Florida, LLC
Lucille H. Byno, Ph.D., LMFT, CFLE
1334 Timberlane Road, Suite 2
Tallahassee, FL 32312
(603) 913-7948
drlucybyno@gmail.com

Release of Information

I, the undersigned, hereby authorize Lucille H. Byno, Ph.D., LMFT (the therapist) to release the following information:

_____

_____

To:

_____

For the following purposes:

_____

_____

_____

I fully understand the nature and the intent of this authorization. I understand that my consent is completely voluntary, and I may withdraw this authorization, in writing, at any time. I understand that no services will be denied to me solely on the basis of my refusal to consent to this release of information.

This authorization expires three months from the date signed below or following termination of therapy with Lucille H. Byno, Ph.D., LMFT.

_____ _____

Name Date

The undersigned parent(s) or legal guardian(s) hereby agree and also consent on behalf of the minor children identified below.

Parent(s)/Legal Guardian(s)