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Authorization to Request and/or Release Information

Client's Full Name: _____ Date of Birth: _____

I authorize Marina Bystritsky, Ph.D. to request and exchange confidential professional information, including personal, psychological, medical records and opinions, with:

Name of Person or Organization

Street Address

Phone

City/State/Zip Code

Fax

Name of Person or Organization

Street Address

Phone

City/State/Zip Code

Fax

Name of Person or Organization

Street Address

Phone

City/State/Zip Code

Fax

I understand that I have no obligation whatsoever to disclose the requested information and that I may revoke this consent at any time by informing Dr. Bystritsky or the above named parties.

In consideration of this consent, I hereby release Dr. Bystritsky and the above named parties from any and all liability arising therefrom.

Signature of Client or Legal Representative

Date

Print Name

Relationship to Client