SHERIDAN HOUSE FAMILY MINISTRIES COUNSELING CENTER
1700 S. Flamingo Road, Davie, FL 33325 (954) 880-9595 www.sheridanhouse.org

AUTHORIZATION FOR RELEASE/RETRIEVAL OF INFORMATION

I, _____, authorize Sheridan House Counseling Center to release information to, and retrieve information from, the following entity regarding treatment for myself and/or my child:

Entity Name: _____

Address: _____

_____

Phone: _____

Email: _____

The content of this disclosure has been discussed with my counselor. This release and/or retrieval of information is for professional and confidential use on my behalf or on behalf of my child. I acknowledge that this authorization is valid until _____, either one year after the date of my signature below or another date determined by myself and my counselor.

_____	_____
Printed Name of Client	Client's Date of Birth
_____	_____
Printed Name of Parent (if client is a minor)	Relationship to Minor
_____	_____
Client Signature (Parent Signature if client is a minor)	Date
_____	_____
Therapist Signature	Date